DMERC Dialogue

Durable Medical Equipment Regional Carrier (DMERC) Region D

July 2004 (Summer) *General Release 04-3*

A Medicare Newsletter for Region D DMEPOS Suppliers - A service of CIGNA HealthCare Medicare Administration

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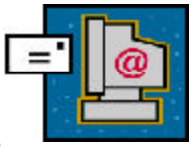

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From the Medical Director...

Robert Hoover, Jr., MD, MPH

BAM!!! Let's Take It Up A Notch

By now most of you are familiar with the Comprehensive Error Rate Testing (CERT) program from previous articles in the *DMERC Dialogue*. CERT is the Centers for Medicare & Medicaid Services (CMS) initiative that measures claim payment errors in the Medicare program.

Through oversight audits by the CERT contractor, AdvanceMed, contractors like CIGNA Medicare receive data on various types of claim errors and use this data to develop strategies to reduce errors in the Medicare program.

One of the major types of error is lack of documentation. Although suppliers who have claims chosen for CERT review are informed in their notification letter of the importance of submitting documentation to AdvanceMed, there is still an unacceptably high non-response rate. This is occurring even after several follow-up letters are sent. Consequently, CMS has asked contractors to make phone contact with suppliers who have not responded after 30 days.

Why is CMS so interested in a response?

The Medicare error rate has greater validity when there is complete documentation for a claim. Without a response from suppliers, by default, the claim must be denied because the contractor is unable to determine if the item or service was truly medically necessary.

Why should suppliers care?

A couple of reasons. First, you are helping to accurately determine the magnitude of claim errors in the Medicare program. Contractors, like CIGNA Medicare, use CERT data to develop educational programs that assist suppliers in the correct submission of claims. Fewer claim errors means lower denial rates which saves

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BAM!!! **Let's Take It Up A Notch** ***(cont'd)***

money and resources for both the contractor and the supplier.

Second, if documentation is not submitted to AdvanceMed, the claim is denied and an overpayment assessed.

So don't be surprised if someone from CIGNA Medicare calls to follow-up on a CERT documentation request. They're just trying to make sure that Medicare data is as accurate as possible and, hopefully, helping you avoid an overpayment on your claim.

MEDICAL POLICY

Wheelchair Options/Accessories And Wheelchair Seating – Policy Revisions

Wheelchair Options/Accessories

The Wheelchair Options and Accessories policy has been converted to the Local Coverage Determination (LCD) and Policy Article format and is included in the July 2004 supplier manual update. Refer to the Revision History section of the LCD and the Other Comments section of the Policy Article for the complete list of changes. The following changes are particularly noteworthy.

Information relating to wheelchair seat and back cushions and positioning accessories has been moved from the Wheelchairs Options/Accessories policy to the Wheelchair Seating policy.

The definition of flat free inserts has been revised to include the nonremovable foam filling in foam-filled rubber tires. This revised definition is retroactive and rescinds the coding guidelines that were in the revised LMRP that was effective in January 2004.

Codes E1225 and E1226 which describe manually reclining wheelchair backs may be used when these options are provided with either a manual or power wheelchair (despite the fact that the code narrative says "Manual wheelchair accessory"). This change is also retroactive to dates of service on or after 1/1/04.

Wheelchair Seating

In the Wheelchair Seating LCD, Documentation Requirements section, the criteria for use of the KX modifier with combination skin protection and positioning seat cushions was revised to agree with the coverage criteria in the Indications and Limitations of Coverage section.

In the revision of the Wheelchair Seating Policy Article, codes E1025-E1027 (pediatric positioning accessories) and K0115 and K0116 (custom fabricated seating systems) were added to the list of codes that are invalid for claim submission to the DMERC. The standard grace period applies – see article in the Spring 2004 *DMERC Dialogue*.

Codes K0660 and K0661 (general use back cushions) have been added to the list of codes requiring a written Coding Verification Review by the SADMERC before a product may be billed using those codes.

The DMERCs request that manufacturers submit pricing information for cushions that are sent to the SADMERC for Coding Verification review. For further information, refer to the "Wheelchair Cushion Codes and Definitions" article in this bulletin.

LMRP Conversion To LCD And Policy Articles

As noted in the Spring 2004 *DMERC Dialogue* (see "Medical Policies – New Format," page 6) we provided information about the new format that is being used for local coverage determinations (LCDs). Contractors are required to convert all existing local medical review policies (LMRPs) to this format over the next 18 months. We anticipate converting several LMRPs during each publication cycle. Some of the conversions will be straight from the original policy and thus contain no changes to the content. Others will incorporate revisions to the policy content; therefore, we encourage you to review the revision history and the related policy article carefully.

The following LMRPs have been converted to LCDs and are included in the *DMERC Region D Supplier Manual* update for July 2004 and posted at http://www.cignamedicare.com/dmerc/lmrp_lcd/index.html:

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- Cold Therapy
- Continuous Positive Airway Pressure System (CPAP)
- External Breast Prosthesis
- External Infusion Pumps
- Infrared Heating Pad Systems
- Wheelchair Options/Accessories
- Seat Lift Mechanisms

Clarification – Coding Of Night Splints For Plantar Fasciitis

Plantar fasciitis is an inflammation of the heel of the foot typically resulting from trauma to the deep tissues (i.e., plantar fascia). One method of treatment is with an orthosis that maintains the affected foot in a flexed position and is worn at night. Commonly called "night splints", this orthosis is covered under the Ankle-Foot/Knee-Ankle-Foot Orthosis local coverage determination (LCD) as a static ankle-foot orthosis and coded L4396. The ICD-9 diagnosis code for plantar fasciitis is 728.71.

This information has been added to the local coverage determination (LCD) and Policy Article that appear in the July 2004 *DMERC Region D Supplier Manual* update.

External Infusion Pumps – Coverage For Gallium Nitrate Added

Gallium nitrate, marketed as Ganite™ (Genta) has been added to the list of drugs covered for use with an infusion pump under the External Infusion Pump local coverage determination (LCD). It is covered for the treatment of symptomatic cancer-related hypercalcemia (ICD-9 diagnosis code 275.42).

Use code J7799 (NOC drugs, other than inhalation drugs, administered through DME) for gallium nitrate. One unit of service= 500mg.

Refer to the LCD and related Policy Article for additional information.

New Immunosuppressive Drug

Effective for dates of service on or after February 27, 2004, mycophenolic acid (Myfortic®) is covered under the Immunosuppressive Drugs local medical review policy (LMRP). Until a new HCPCS code is established for this drug, claims must be billed using the miscellaneous code J7599 or, if billing in the national council for prescription drug programs (NCPDP) format, the national drug code (NDC) number. A revision to the Immunosuppressive Drugs LMRP will be published in a future edition of the *DMERC Region D Supplier Manual*.

COVERAGE AND BILLING

Billing Reminder - Elevating Leg Rests

Two HCPCS codes are available for use when billing elevating leg rests. Which code to use depends on whether the wheelchair base is being rented or is a purchased item AND whether or not billing is for a single leg rest or a pair.

HCPCS code K0195 (Elevating leg rests, pair – for use with capped rental wheelchair base) must only be used when billing 2 leg rests for a rented wheelchair. The appropriate modifiers must be appended (i.e., RR and KH, KI, or KJ) and the correct number of services is 1. Code K0195 **must not** be used for leg rests provided for a purchased wheelchair.

HCPCS code E0990 (Wheelchair accessory, elevating leg rest, complete assembly, each) should be used when only 1 leg rest is provided for either a rented or purchased wheelchair or when 2 leg rests are provided with a purchased wheelchair. The appropriate modifiers must be appended (i.e., NU, UE or RR).

Correct Coding Of Flutter® And Acapella™ Devices

HCPCS code E0484 was added in 2003 to describe devices that assist in mobilizing thick or tenacious secretions. Data analysis indicates that claims for these items are being incorrectly submitted using HCPCS code E1399 (Durable medical equipment, miscellaneous). The correct HCPCS code is:

E0484 - Oscillatory positive expiratory pressure device, nonelectric, any type, each

Currently this HCPCS code is assigned to only two products, the Flutter® device (Scandipharm Inc.) and the Acapella™ (DHD Healthcare Corp.). Manufacturers with a similar device that they feel should be billed with this code are advised to consult the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) with any questions regarding the correct coding for these types of items.

Humidifiers – HCPCS Codes E0550, E0555, E0560, E0561, And E0562

Several HCPCS codes are available to suppliers when billing humidifiers. The code chosen depends on the type of respiratory device with which the humidifier will be used and the payment classification for the respiratory device.

Humidifiers should not be billed separately when used with a rented ventilator (E0450, E0454, and E0461) or rented oxygen equipment. For ventilators and oxygen equipment, payment for accessories such as humidifiers (HCPCS codes E0550, E0555, E0560) is included in the monthly rental payment. When humidifiers are billed with a rented volume ventilator or rented oxygen equipment that is covered by Medicare, they will be denied as not separately payable. If used with a rented volume ventilator or oxygen equipment that is not cov-

ered by Medicare, the humidifier will be denied with the same type of denial as the equipment.

HCPCS codes E0561 and E0562 may only be billed when used with a continuous positive airway pressure system or a respiratory assist device, and must not be billed with a ventilator or oxygen equipment.

Ventilator accessories are covered and separately payable if the patient has a purchased ventilator which is medically necessary. Oxygen accessories such as humidifiers are covered only when the beneficiary purchased oxygen equipment before June 1, 1989. If a humidifier (E0550, E0555, E0560) is provided with oxygen equipment purchased on or after June 1, 1989, it will be denied as noncovered.

Rules For Maintenance And Servicing Claims

Suppliers must not submit claims for maintenance and servicing until all claims for the capped rental item have been paid and six months have passed from the end of the final paid rental month. Furthermore, suppliers must not bill for maintenance and servicing codes on the same claim as codes for the rental itself.

Maintenance and servicing for an item billed on the same claim with the rental of the same item will be denied. A claim must be resubmitted for the maintenance and servicing fee only.

Written Order Prior To Delivery – HCPCS Codes Added

Effective with dates of service on or after July 1, 2004, the following HCPCS codes will be included in the list of items requiring a written order prior to delivery. Refer to the Wheelchair Seating local coverage determination and policy article for information concerning coverage.

E0955 Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each
E0956 Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each
E0957 Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each
E0960 Wheelchair accessory, shoulder harness/ straps or chest strap, including any type mounting hardware
E0966 Manual wheelchair accessory, headrest extension, each
E0992 Manual wheelchair accessory, solid seat insert
E1028 Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
K0650 General use wheelchair seat cushion, width less than 22 inches, any depth
K0651 General use wheelchair seat cushion, width 22 inches or greater, any depth
K0652 Skin protection wheelchair seat cushion, width less than 22 inches, any depth
K0653 Skin protection wheelchair seat cushion, width 22 inches or greater, any depth
K0654 Positioning wheelchair seat cushion, width less than 22 inches, any depth
K0655 Positioning wheelchair seat cushion, width 22 inches or greater, any depth
K0656 Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth
K0657 Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth
K0658 Custom fabricated wheelchair seat cushion, any size
K0659 Wheelchair seat cushion, powered
K0660 General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
K0661 General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
K0662 Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware
K0663 Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware
K0664 Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware
K0665 Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type mounting hardware
K0666 Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
K0668 Replacement cover for wheelchair seat cushion or back cushion, each
K0669 Wheelchair seat or back cushion, no written coding verification from SADMERC

Wheelchair Cushion Codes And Definitions

Effective July 1, 2004, the existing HCPCS codes for wheelchair cushions will become invalid for billing to Medicare. Newly created codes for wheelchair cushions include manufacturing standards that must be met in order for a wheelchair cushion to qualify for any given code. Some of these standards include fire resistance, pressure reduction, skin protection and positioning among others. The Wheelchair Seating policy article requires that all wheelchair cushions billed to Medicare undergo a Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Coding Verification Review with formal assignment of a code before they are billed to Medicare. Under the Wheelchair Seating local coverage determination (LCD), cushions that have not undergone this coding review will be denied as not medically necessary.

Each manufacturer must submit product information, test results, and/or other supporting documentation for each wheelchair cushion line. The information must detail the results of testing for, and compliance with, each of the stated standards along with one sample of each wheelchair cushion line in order to receive a SADMERC Coding Verification Letter. Cushions that have not been through the SADMERC Coding Verification Review process will be assigned a non-tested general use HCPCS code.

Additional details are available on the SADMERC Web site (http://www.palmettogba.com/palmetto/other.nsf/Home/Other+Medicare+ Partners+ SADMERC +Home?OpenDocument) or in the Wheelchair Seating local coverage determination (LCD) and Policy Article.

CERT Revisited

[This article was published "From the Medical Director" in the July 2003 DMERC Dialogue and is being republished (with a revision to number 2 and 4) as a reminder.]

As I wrote in the Winter 2000 *DMERC Dialogue*, the Comprehensive Error Rate Testing program (CERT) was implemented to allow the Centers for Medicare & Medicaid Services (CMS) to monitor claims payment accuracy. Each month, a sample of claims is examined by an independent auditor (AdvanceMed) and the results reviewed to determine if claims were paid in accordance with Medicare guidelines. Region D claims paid in error are referred back to CIGNA Medicare for collection of an overpayment or refund for underpayment. Now almost three years into the program, the DMERCs continue to track the types of errors and provide education to the supplier and physician community. By far, the most common CERT error is related to documentation. Below are some tips to avoid documentation errors and subsequent overpayment requests.

1. Respond to the documentation request from AdvanceMed. Should you receive a letter from AdvanceMed asking for your records pertaining to a claim(s), please respond promptly and provide the information requested in the letter. Even though you may have initially been paid for the claim, failure to respond to the documentation request will result in denial of the claim and a request for an overpayment refund to Medicare. (Documentation information is published in Chapter 3 of the *DMERC Region D Supplier Manual*.)

2. Maintain complete and accurate records. The *DMERC Region D Supplier Manual*, available online at www.cignamedicare.com/dmerc/dmsm/index.html, has details about orders and documentation that must be present in a supplier's files, including which items must be in a supplier's files before a claim can even be submitted to Medicare. (Refer to Chapter 3 of the *DMERC Region D Supplier Manual* for information about documentation and Chapter 9 regarding requirements detailed in the local medical review policies/local coverage determinations and policy articles.)

3. Ensure orders contain all the required elements, including a signature and date from the treating physician. As noted in the Winter 2003 *DMERC Dialogue*, incomplete orders are one of the top errors noted by the CERT program, particularly in the policy groups of glucose monitors, ostomy supplies, urological supplies and nebulizer drugs. For these policy groups, remember to ensure that the order contains the following elements:

- Quantity to be dispensed
- Frequency of use
- ICD-9 diagnosis code or narrative diagnosis
- Treating physician's signature and date
- Specific type of supply ordered

(Documentation information is published in Chapter 3 of the *DMERC Region D Supplier Manual*.)

4. For items requiring a written order prior to delivery, HAVE A WRITTEN ORDER PRIOR TO DELIVERY! Very few items in Medicare have this requirement. Below is the list:

- Support Surfaces
- Transcutaneous Nerve Stimulators (TENS)
- Seat Lift Mechanisms
- Negative Pressure Wound Therapy (NPWT)

- Power Operated Vehicles (POV)
- Certain wheelchair seating accessories

(Information regarding orders is published in Chapter 3 of the *DMERC Region D Supplier Manual*.)

5. For items requiring a Certificate of Medical Necessity (CMN), ensure that the form is signed AND dated by the treating physician. In addition, if there are any corrections necessary, make sure that the corrections are initialed and dated by the treating physician. (Information regarding CMNs is published in Chapter 4 of the *DMERC Region D Supplier Manual*.)

As always, CIGNA Medicare's goal is to help suppliers get their claims processed in an accurate and timely manner. Remembering these documentation tips will help prevent claim errors and claim denials.

Completion Of Section B Of The Certificate Of Medical Necessity Form

Section B of the Certificate of Medical Necessity (CMN) may not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed by the treating physician. Following are rules for completing the various fields in Section B.

Estimated Length of Need - This indicates the estimated length of need (the length of time (in months) the physician expects the patient to require use of the ordered item). If the treating physician expects that the patient will require the item for the duration of his/her life, 99 is entered. For recertification and revision CMNs, the cumulative length of need (the total length of time in months from the initial date of need) is entered.

Diagnosis Codes - Listed in the first space is the ICD-9 code that represents the primary reason for ordering this item. Additional ICD-9 codes that would further describe the medical need for the item (up to 3 codes) are also listed. A given CMN may have more than one item billed, and for each item, the primary reason for ordering may be different. For example, a CMN is submitted for a manual wheelchair (K0001) and elevating leg rests (K0195). The primary reason for K0001 is stroke, and the primary reason for K0195 is edema.

Question Section - This section is used to gather clinical information regarding the patient's condition, the need for the DME, and supplies.

Name of Person Answering Section B Questions - If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician, or a physician employee) answers the questions in Section B, he/she must **print** his/her name, give his/her professional title, and the name of his/her employer, where indicated. If the treating physician answered the questions, this space may be left blank.

Elimination Of The 90-Day Grace Period For Billing Discontinued ICD-9-CM Codes

Medlearn Matters Article Number: MM3094

Provider Types Affected - All physicians, practitioners, and suppliers who use ICD-9-CM Codes in billing Medicare carriers and Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed

Impact to You - Medicare systems will begin enforcing HIPAA standards on October 1, 2004, requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is provided.

What You Need to Know - Physicians, practitioners, and suppliers should be aware that CMS is instructing carriers and DMERCs to eliminate the 90-day grace period for billing discontinued ICD-9-CM diagnosis codes effective October 1, 2004.

What You Need to Do - Adopt the new codes in your billing processes effective October 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of your claim.

Background - Medicare has previously permitted a 90-day grace period after the annual October 1 implementation of an updated version of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. This grace period gave physicians, practitioners and suppliers time to become familiar with the new codes and learn about the discontinued codes.

During this 90-day grace period (October 1 through December 31 of each year), physicians, practitioners, and suppliers could use either the previous or the new ICD-9-CM diagnosis codes. For claims received on or after January 1, the updated ICD-9-CM codes were required to be used, and claims received with discontinued diagnosis codes were rejected as Returned Unprocessable Claims (RUCs).

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires the use of national/medical code sets that are valid at the time that the service is provided, and ICD-9-CM is a national/medical code set.

Therefore, the Centers for Medicare & Medicaid Services (CMS) **can no longer allow a 90 day grace period** for physicians, practitioners and suppliers to learn about the discontinued ICD-9 codes.

Providers can view the new, revised, and discontinued ICD-9-CM diagnosis codes at http://www.cms.hhs.gov/medlearn/icd9code.asp. CMS updates this site annually after the updated diagnosis codes are published in the Federal Register, which usually occurs by May 1 of each year.

Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers and DMERCs will no longer be able to accept discontinued codes for dates of service after the date on which the code is discontinued. This is a HIPAA compliancy issue.

Implementation - October 1, 2004. This is the date on which Medicare's claims processing systems will be changed.

Related Instructions - The *Medicare Claims Processing Manual*, Chapter 23, Section 10, Subsection 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. The relevant revisions to Subsection 10.2 are the following:

10.2 – Relationship of ICD-9-CM Codes and Date of Service (Rev. 1, 10-01-03) PM B-02-027 (CR-2108), B-03-063, B-02-064, B-03-002

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since ICD-9-CM is a medical code set, effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in Table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis code grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year. Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004. After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: http://www.cms.hhs.gov/medlearn/icd9code.asp.

For more information about the relationship of ICD-9-CM diagnosis codes and dates of service, go to Chapter 23, available at: http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

To view the actual instruction issued by CMS to your Medicare carrier, please go to: http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf

For more information on HIPAA's rules that relate to claims submission, other transactions, and code sets, please visit: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp

Manualization of POS Code Set Program Memorandum; Revision To Group Home Code Description

Medlearn Matters Article Number: MM3087

Provider Types Affected - Physicians, suppliers, and providers who bill Medicare carriers.

Provider Action Needed - Physicians, suppliers, and providers should note that this article addresses only a new definition for the Place of Service (POS) Code for Group Homes. Other POS code set information was issued on May 16, 2003 in CMS Program Memorandum/Transmittal B-03-040 and Change Request 2730, "Update of the Place of Service (POS) Code Set." That other information remains unchanged.

Background - Effective April 1, 2004, the description of POS code 14 (Group Home) will be as follows:

"A residence, with shared living areas, where clients receive supervision and other services, such as social and/or behavioral services, custodial services, and minimal services (e.g., medical administration)."

Once again, the remainder of the updated POS code set remains as presented in Program Memorandum B-03-040, which may be found at: http://www.cms.hhs.gov/manuals/pm_trans/B03040.pdf.

Additional Information - The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/pm_trans/R121CP.pdf.

If you have any questions, please contact your carrier/ intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Reminder To Stop Duplicate Billings

Medlearn Matters Article Number: SE0415

Provider Types Affected - Providers and suppliers who bill Local Part B Carriers and Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed
Impact to You - If you submit more than one claim for the same item or service, you can expect your duplicate claims to be denied. In addition, duplicate claims: 1) may delay payment; 2) could cause you to be identified as an abusive biller; or 3) if a pattern of duplicate billing is identified, may generate an investigation for fraud.
What You Need to Know - Some providers routinely submit duplicate claims to Local Part B Carriers and DMERCs for a single service encounter. This is inappropriate. CMS asks providers and suppliers to discontinue this practice. Unlike other health insurance payers where it is customary to bill until paid, multiple or repetitive billing to Medicare for a particular item or service is improper.
What You Need to Do - Refrain from submitting multiple claims to Medicare for the same item or service. Make sure that your billing staff or third party billing service knows Medicare claims filing rules.

Background - Some providers are submitting duplicate claims to DMERCs and Local Part B Carriers for a single service encounter. A duplicate claim is a claim submitted to one or more Medicare contractors from the same provider for the:

- **Same beneficiary**; for the
- **Same item or service**; for the
- **Same date** of service.

Although CMS believes that most providers and suppliers are not deliberately trying to receive duplicate payment by submitting duplicate claims, CMS wants to remind providers and suppliers that submitting such duplicate claims for the same service encounter is inappropriate and asks you to discontinue this practice. Moreover, please keep in mind that Medicare does not make payment for duplicate claims that you might submit. CMS will pay the first claim that is approved and will deny subsequent claims for the same service as duplicates. Also note that, although Medicare is prohibited by law from paying claims immediately, over 90% of clean, payable claims are paid within 30 days.

Therefore, once you submit a claim, please don't keep re-submitting until you get paid. One submission is all that is required. CMS suggests that if you have not received payment after 30 days and are concerned about your payment, contact your carrier or DMERC via the toll-free lines they have to check on claims status or use other electronic claims status inquiry functions to check with your carrier on claim status.

If you do not know the toll-free number, you can find it at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

CMS appreciates your cooperation in avoiding duplicate billing. Doing so will help Medicare process all claims more efficiently and cost-effectively so that timely payments can continue to be made.

Correction "Epoetin And Darbepoetin – New Codes"

In the Spring 2004 *DMERC Dialogue* , and as a What's New article posted on January 20, 2004, we published "Epoetin and Darbepoetin – New Codes." The article stated that on electronic claims the hematocrit must be entered as a three-digit value with an implied single decimal point. After the article was published we found that the information was incorrect. The article should have stated, "on electronic claims submitted in the ***National Standard Format (NSF)***, the hematocrit must be entered as a three-digit value with an implied single decimal point."

TPN Lessons Learned

The DMERC Medical Review staff recently conducted a review of total parenteral nutrition (TPN) claims in order to determine the most common mistakes made in the submission of these claims. The following reminders are based on the reviewers' findings.

1. In order to qualify for Medicare coverage, the beneficiary's condition must fall under one of the covered situations described in the Parenteral Nutrition local medical review policy (LMRP) and the beneficiary must need TPN therapy for a minimum of three months.

For example, a malnourished beneficiary who is only going to receive TPN for 2-3 weeks prior to surgery does not qualify for coverage.

2. A beneficiary does not qualify under LMRP Situation A (recent massive small bowel resection leaving ≤ 5 feet of small bowel beyond the ligament of Treitz) unless the TPN therapy begins within three months of the date of surgery. If TPN therapy is initiated more than three months following surgery, the beneficiary must qualify under one of the other covered situations in order for Medicare to approve payment.

3. When submitting the initial claim for beneficiaries who meet Situation B TPN coverage criteria (severe short bowel syndrome), the supporting medical records should include intake and output records.

4. A beneficiary with a mechanical small bowel obstruction does not qualify under Situation D ***unless*** the obstruction is ***complete*** and surgery is not an option. In order for a beneficiary with a partial obstruction to qualify for TPN coverage, records must document a failed enteral nutrition tube trial.

5. Payment will not be approved under Situation E (severe fat malabsorption) unless the medical records include a qualifying 72 hour fecal fat test.

6. If the fecal fat test shows moderate fat malabsorption or the diagnosis of malabsorption is confirmed by a method other than a 72 hour fecal fat test (Sudan stain, d-xylose test, etc.), a failed tube trial is required before TPN coverage will be approved.

7. Medical records submitted to support that a beneficiary qualifies for TPN coverage due to a severe gastrointenstinal mobility disturbance (Situation F) must include diagnostic test results that confirm the gastric to right colon transit time is greater than 6 hours.

8. TPN is not covered for gastric to right colon transit times between 3-6 hours unless there is documented evidence of a failed tube trial.

9. There is no Medicare benefit category under which to cover TPN that does not meet the criteria in one of the situations described in the medical policy, or that meet the criteria in the list of noncovered uses of TPN. Bill TPN claims that are not covered under the Prosthetic benefit category coverage with the modifier GY. For example, TPN being administered to treat a temporary condition is not covered and would be billed with modifier GY. An Advance Beneficiary Notice (ABN) is not applicable in this example. An ABN is not applicable for items that are denied because they are statutorily excluded from coverage or that do not meet the definition of any Medicare benefit category.

For additional assistance with TPN claims, refer to the TPN resources posted on the DMERC Medical Review page of the CIGNA Medicare Web site (http://www.cignamedicare.com/dmerc/mr/index.html).

FEE SCHEDULE

New Payment Allowance Percentages For DMERC Drugs

Medlearn Matters Article Number: MM3153

Provider Types Affected - Suppliers and other providers who bill for certain drugs and biologicals not paid on a cost or prospective payment basis.

Provider Action Needed - Affected providers and suppliers should note that this instruction adds a payment limit percentage for the drug Capecitabine (Xeloda).

Background - Effective January 1, 2004, the payment limit allowance for J8520 (Capecitabine, 150 mg) and J8521 (Capecitabine, 500 mg) will be 90 percent of the April 1, 2003 Average Wholesale Price (AWP). While this change is effective for these codes as of January 1, 2004, Medicare does not plan to search their files to make any adjustment to claims already processed, unless the provider brings such claims to the attention of their DMERC or fiscal intermediary (FI).

Implementation - The implementation date for this instruction is March 26, 2004.

Additional Information - The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/pm_trans/R131CP.pdf

If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

July Quarterly Update For 2004 DMEPOS Fee Schedule

Medlearn Matters Article Number: MM3253

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed

Impact to You - This instruction provides details regarding the July 2004 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedules.

What You Need to Know - The 2004 fee schedule amounts for selected Healthcare Common Procedure Coding System (HCPCS) codes are being revised to correct calculation errors.

What You Need to Do - Refer to the Background and Additional Information sections of this instruction for further details regarding these changes.

Background - The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Section 1834(a), (h), and (i)), and payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

This instruction provides specific details regarding the July quarterly update for the 2004 DMEPOS fee schedule.

Codes **K0630 through K0649** were added to the HCPCS effective April 1, 2004. The fee schedule amounts for these codes were not computed in time to be implemented as part of the April quarterly update and will be implemented as part of the July quarterly update. The Durable Medical Equipment Regional Carriers (DMERCs) have calculated local fee schedule amounts for purposes of paying claims for codes K0630 through K0649 received prior to July 1, 2004.

Codes **K0650 through K0669** are being added to the HCPCS effective July 1, 2004. The fee schedule amounts for these codes will not be computed in time to be implemented as part of the July quarterly update because the products that fall under these codes have not yet been identified. DMERCs and Regional Home Health Intermediaries (RHHIs) will determine the payment amounts for K0650 through K0669 when such claims are received for services on or after July 1, 2004 through September 30, 2004. The fee schedule amounts for codes K0650 through K0669 will be implemented as part of the October quarterly update.

Codes **A4216, A4217, A4217AU, L5782, and L8511 through L8514** have been paid on an individual consideration basis by the DMERCs and Fiscal Intermediaries (FIs). Fee schedule amounts are being established for these codes as part of the July quarterly update. For service in 2004, FIs will use the fee schedule amount for A4217 without the AU modifier.

Code **A4290** was added to the fee schedule under the prosthetic device category. It does not qualify, however, for separate payment under the prosthetic device benefit. This code is being removed from the DMEPOS fee schedule file as part of the July quarterly update.

Also, please note that codes **E0973, E0990, E1225, and E1226** have been added to the list of codes requiring a Certificate of Medical Necessity, while code E0300 has been removed from that list.

Implementation - The implementation date for this instruction is July 6, 2004.

Related Instructions - The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule), which can be reviewed at the following CMS Website: http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

Additional Information - The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR3253 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

In addition, a comprehensive overview of the HCPCS can be found at the following CMS Website: http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp

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NOTE: In the July quarterly update for the 2004 DMEPOS fee schedule, there were no calculation errors as stated in the "What You Need to Know" section in the above article. Therefore, no revisions were required. The fees that were added to the July quarterly update were previously priced based on individual consideration.

July Quarterly Update DMEPOS Fee Schedule

The changes for the 3rd quarterly update of the 2004 DMEPOS Fee Schedule are listed below.

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

The following codes have been added to the fee schedule, effective for dates of service on or after January 1, 2004.

States	A4216	A4217	A4217AU	L5782	L8511	L8512	L8513	L8514
AK	$0.69	$1.53	$1.53	$3,320.90	$57.26	$1.70	$4.08	$74.24
AZ	$0.44	$3.13	$3.13	$3,320.90	$57.26	$1.70	$4.08	$74.24
CA	$0.45	$2.66	$2.66	$3,320.90	$57.26	$1.70	$4.08	$74.24
HI	$0.67	$2.70	$2.70	$3,320.90	$57.26	$1.70	$4.08	$74.24
IA	$0.45	$3.13	$3.13	$3,385.77	$58.40	$1.73	$4.17	$75.70
ID	$0.38	$2.66	$2.66	$3,320.90	$57.26	$1.70	$4.08	$74.24
KS	$0.38	$2.66	$2.66	$3,385.77	$58.40	$1.73	$4.17	$75.70
MO	$0.45	$2.66	$2.66	$3,385.77	$58.40	$1.73	$4.17	$75.70
MT	$0.45	$2.66	$2.66	$3,439.78	$59.30	$1.78	$4.24	$76.90
ND	$0.43	$3.01	$3.01	$3,439.78	$59.30	$1.78	$4.24	$76.90
NE	$0.44	$2.72	$2.72	$3,385.77	$58.40	$1.73	$4.17	$75.70
NV	$0.45	$2.66	$2.66	$3,320.90	$57.26	$1.70	$4.08	$74.24
OR	$0.38	$3.13	$3.13	$3,320.90	$57.26	$1.70	$4.08	$74.24
SD	$0.39	$3.13	$3.13	$3,439.78	$59.30	$1.78	$4.24	$76.90
UT	$0.45	$2.66	$2.66	$3,439.78	$59.30	$1.78	$4.24	$76.90
WA	$0.38	$3.13	$3.13	$3,320.90	$57.26	$1.70	$4.08	$74.24
WY	$0.45	$3.13	$3.13	$3,439.78	$59.30	$1.78	$4.24	$76.90

The HCPCS codes K0630 - K0649 have been added to the fee schedule with the effective date of service on or after April 1, 2004. For HCPCS codes that indicate "IC" (individual consideration), you will need to send product information with suggested retail price for the item being billed.

States	K0630	K0631	K0632	K0633	K0634	K0635
AK	$27.08	IC	$57.23	IC	$55.58	$66.09
AZ	$27.08	IC	$57.23	IC	$55.58	$66.09
CA	$27.08	IC	$57.23	IC	$55.58	$66.09
HI	$27.08	IC	$57.23	IC	$55.58	$66.09
IA	$27.63	IC	$58.35	IC	$56.65	$67.35
ID	$27.08	IC	$57.23	IC	$55.58	$66.09
KS	$27.63	IC	$58.35	IC	$56.65	$67.35
MO	$27.63	IC	$58.35	IC	$56.65	$67.35
MT	$28.05	IC	$59.26	IC	$57.59	$68.43
ND	$28.05	IC	$59.26	IC	$57.59	$68.43
NE	$27.63	IC	$58.35	IC	$56.65	$67.35
NV	$27.08	IC	$57.23	IC	$55.58	$66.09
OR	$27.08	IC	$57.23	IC	$55.58	$66.09
SD	$28.05	IC	$59.26	IC	$57.59	$68.43
UT	$28.05	IC	$59.26	IC	$57.59	$68.43
WA	$27.08	IC	$57.23	IC	$55.58	$66.09
WY	$28.05	IC	$59.26	IC	$57.59	$68.43

States	K0636	K0637	K0638	K0639	K0640	K0641
AK	$355.52	$62.60	IC	$137.60	$696.67	IC
AZ	$355.52	$62.60	IC	$137.60	$696.67	IC
CA	$355.52	$62.60	IC	$137.60	$696.67	IC
HI	$355.52	$62.60	IC	$137.60	$696.67	IC
IA	$362.47	$63.83	IC	$140.27	$710.30	IC
ID	$355.52	$62.60	IC	$137.60	$696.67	IC
KS	$362.47	$63.83	IC	$140.27	$710.30	IC
MO	$362.47	$63.83	IC	$140.27	$710.30	IC
MT	$368.26	$64.85	IC	$142.52	$721.63	IC
ND	$368.26	$64.85	IC	$142.52	$721.63	IC
NE	$362.47	$63.83	IC	$140.27	$710.30	IC
NV	$355.52	$62.60	IC	$137.60	$696.67	IC
OR	$355.52	$62.60	IC	$137.60	$696.67	IC
SD	$368.26	$64.85	IC	$142.52	$721.63	IC
UT	$368.26	$64.85	IC	$142.52	$721.63	IC
WA	$355.52	$62.60	IC	$137.60	$696.67	IC
WY	$368.26	$64.85	IC	$142.52	$721.63	IC

States	K0642	K0643	K0644	K0645	K0646	K0647	K0648	K0649
AK	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
AZ	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
CA	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
HI	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
IA	$222.13	IC	IC	IC	$428.08	$1,056.59	$642.34	$838.26
ID	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
KS	$222.13	IC	IC	IC	$428.08	$1,056.59	$642.34	$838.26
MO	$222.13	IC	IC	IC	$428.08	$1,056.59	$642.34	$838.26
MT	$225.65	IC	IC	IC	$434.94	$1,073.46	$652.57	$851.64
ND	$225.65	IC	IC	IC	$434.94	$1,073.46	$652.57	$851.64
NE	$222.13	IC	IC	IC	$428.08	$1,056.59	$642.34	$838.26
NV	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
OR	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
SD	$225.65	IC	IC	IC	$434.94	$1,073.46	$652.57	$851.64
UT	$225.65	IC	IC	IC	$434.94	$1,073.46	$652.57	$851.64
WA	$217.86	IC	IC	IC	$419.89	$1,036.35	$630.01	$822.21
WY	$225.65	IC	IC	IC	$434.94	$1,073.46	$652.57	$851.64

Wheelchair Cushion - The fees for wheelchair cushion codes K0650 – K0669 have not been established. Refer to the April 2004 (Spring) *DMERC Dialogue* article "Wheelchair Seating – New Policy": "The only products which may be billed using codes K0650 – K0657 and K0662 – K0665 and the only brand name products that may be billed using codes K0658 or K0666 are those products for which a written coding verification has been made by the SADMERC. Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC Web site". Although pricing information is not required on the SADMERC application for Coding Verification Request, it should be submitted along with the request. The wholesale and suggested retail pricing information submitted with the Coding Verification Request will be used to determine the gap-fill fee until the fee schedule is established.

HCPCS Updates

2004 Jurisdiction List

Medlearn Matters Article Number: MM3139

Provider Types Affected - Durable Medical Equipment (DME) Suppliers.

Provider Action Needed - DME Suppliers should be aware of which Medicare contractor to bill for codes provided on the jurisdiction list of the Healthcare Common Procedure Coding System (HCPCS). This HCPCS list for DME Regional Carrier (DMERC) and local carrier jurisdictions is updated on annual basis to provide accurate billing information to providers.

Ensure that your billing staffs know how to find the list and use the list in their billing processes for Medicare claims.

Background - The HCPCS is updated annually to reflect changes in medical practice and the provision of health care. The Centers for Medicare & Medicaid Services (CMS) provides a file containing updated HCPCS codes to Medicare carriers, DMERCs, and intermediaries and to Medicaid State Agencies 60 to 90 days before the implementation of the annual update.

A spreadsheet containing an updated list of the HCPCS for DMERC and Part B local carrier jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) during each year. CMS publishes a recurring update notification annually to notify the DMERCs and Part B carriers that the list has been updated and is available on the CMS Web site.
Both the DMERCs and the local carriers publish this list to educate providers as to which contractor—the DMERC or local Part B carrier—to bill for codes provided on that list.

Additional Information - Updates are available on an Excel spreadsheet on the CMS Web site at: http://www.cms.hhs.gov/suppliers/dmepos

The actual instruction issued to the DMERCs may be found at: http://www.cms.hhs.gov/manuals/pm_trans/R127CP.pdf

Elimination Of The 90-Day Grace Period For HCPCS Codes

Medlearn Matters Article Number: MM3093

Provider Types Affected - All physicians, providers, and suppliers who use Healthcare Common Procedure Coding System (HCPCS) codes in billing Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs).

Provider Action Needed

Impact to You - Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. Use of such codes to bill services provided after the date on which the codes are discontinued will cause your claims to be returned and not paid. **In essence, HCPCS codes must be valid at the time the service is rendered.**

What You Need to Know - Providers should be aware that **effective January 1, 2005**, Carriers, DMERCs, and FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1.

What You Need to Do - To ensure prompt and timely payment of claims, use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, be sure to adopt the new codes.

Background - The Healthcare Common Procedure Coding System (HCPCS) consists of the following two levels of codes:

• Level I codes that are copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4); and

• Level II codes that are five-position alpha-numeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare & Medicaid Services (CMS), the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). The D code series in Level II HCPCS is copyrighted by the American Dental Association.

Medicare has permitted a 90-day grace period after implementation of an updated HCPCS code set to familiarize providers with the new codes and to learn about the discontinued codes. For example, the 2004 HCPCS codes became effective for dates of service on or after January 1, 2004, and Medicare contractors are able to apply a three-month grace period for all applicable discontinued HCPCS codes. This means that the 2003 discontinued HCPCS codes and the new 2004 HCPCS codes will be accepted by carriers from physicians,

suppliers, and providers during the January 2004-March 2004 grace period. This 90-day grace period applies to claims received by the carrier prior to April 1, 2004, which contain the 2003 discontinued codes for dates of service January 1, 2004 through March 31, 2004.

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to **use the medical code set that is valid at the time that the service is provided**.

Therefore CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Providers should be aware that effective January 1, 2005, Carriers, DMERCs, and Fiscal Intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. In addition, effective January 1, 2005, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS updates.

In order for providers to know about the new, revised, and discontinued numeric CPT-4 codes for the upcoming year, they should obtain the American Medical Association's CPT-4 coding book that is published each October. CMS posts on its Web site the annual alphanumeric HCPCS file for the upcoming year. The CMS Web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp.

Physicians, providers, and suppliers should be aware that Medicare systems will begin to reject such discontinued codes, beginning on January 1, 2005, if the codes were not effective on the date of service. Such claims will be returned to the submitter for correction.

This is a HIPAA compliancy issue.

Implementation - July 6, 2004. While this is the date on which Medicare's claims processing systems will be changed to enforce these new rules, the systems will not apply these rules until January 1, 2005.

Related Instructions - The *Medicare Claims Processing Manual*, Chapter 23, Section 20 (Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)), Subsection 20.4 (Deleted HCPCS Codes/Modifiers) was revised and is included below (changes bolded and italicized). Also, **sentences that referred to the three month HCPCS grace period** have been deleted from Subsections 40.1 (Access to Clinical Diagnostic Lab Fee Schedule Files) and 50 (Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)*).*

20.4 – Deleted HCPCS Codes/Modifiers
(Rev.1, 10-01-03) B3-4509.3, HO-442.2

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2002 but received by a carrier/DMERC/intermediary in 2003 should contain codes/modifiers valid in 2002 and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on an annual basis. Each October, CMS releases the annual HCPCS file to carriers/DMERCs/FIs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. Contractors are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective on January 1 of each year. With each annual HCPCS update, CMS has permitted a 90-day grace period for billing discontinued HCPCS codes for dates of service January 1 through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical codes sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

Contractors must eliminate the 90-day grace period from their system effective with the January 1, 2005, HCPCS update. Contractors will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31. Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the annual alphanumeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access CMS Web site to see the new, revised, and discontinued alphanumeric codes for the upcoming year. The CMS Web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

Carriers and DMERCs must continue to reject services submitted with discontinued HCPCS codes. FIs must continue to return to the provider (RTP) claims containing deleted codes.

See the *Medicare Claims Processing Manual*, Chapter 22, "Remittance Notices to Providers."

For more information on HCPCS, visit the CMS Website at: http://cms.hhs.gov/medicare/hcpcs.

For more information on HIPAA and its impact on claims submission, please visit the CMS HIPAA web site at: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp.

HCPCS Code L0474

Code L0474 is not a valid code because it is a duplicate of code L0470. The correct code to use when billing for this type of device is HCPCS code L0470 (TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment). Effective for claims processed April 23, 2004 and after claims billed with code L0474 are denied as invalid.

Electronic Data Interchange (EDI)

Beneficiary Eligibility Options

As many of our suppliers and software vendors know, the ASC X12 270/271 Health Care Eligibility Benefit Inquiry and Response (Real Time), version 4010A1 is not yet fully operational for Medicare. Pending the production use of that transaction, CMS has instructed the contractors to continue support of all current formats used for eligibility verification.

The formats that Region D DMERC currently supports are the 270/271 Direct Data Entry (DDE) and the National Standard Format (NSF) batch eligibility. The 270/271 DDE allows a supplier to enter an eligibility request and receive an eligibility response instantaneously. The NSF batch eligibility requires the supplier to create a file containing an eligibility request with as many as 99 requests. The file is then uploaded into the Stratus Network, using the same process as uploading a claim file. A response file will be generated after the nightly batch job is completed and the supplier would download a response file just as they would an electronic report. The NSF batch version does require the use of software to create the eligibility request and to read the response file received from Medicare. Medicare does not provide this software.

If you would like to sign up for the Beneficiary Eligibility feature, please complete the DMERC EDI Customer Profile located at www.cignamedicare.com/edi/dmerc/forms. If applying for the NSF batch version, please write "NSF Batch Eligibility" in Section 8 under Additional Instructions.

New Requirement For Q4054 And Q4055 On Electronic Claims

The 837 X12N 4010A1 Implementation Guide, page 115, states the Patient weight is required on claims/encounters involving epoetin (EPO) for patients on dialysis and Medicare Durable Medical Equipment Regional Carriers Certificate of Medical Necessity (DMERC CMN) 02.03 and 10.02.

In January, the DMERCs began covering claims submitted with HCPCS Q4054 (darbepoetin alfa) and Q4055 (epoetin alfa). Effective July 6, 2004, the DMERCs will require the patient weight be sent when these HCPCS codes are submitted. Claims submitted without the patient's weight will be rejected and will need to be corrected and resubmitted.

If you are not sure if your software sends the patient's weight on claims involving these codes, contact your software vendor.

Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document

Medlearn Matters Article Number: MM3177

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed

Impact to You - Physicians, suppliers, and providers should note that this instruction provides revisions to the American National Standards Institute (ANSI) X12N 837 Professional Health Care Claim Companion Document.

What You Need to Know - The revisions to the ANSI X12N 837 Professional Health Care Claim Companion

Document correct errors and omissions in the Companion Document provided previously by Change Request (CR) 2900, Transmittal 29, dated December 19, 2003.

What You Need to Do - Refer to the Background and Additional Information sections of this instruction for further details regarding these changes.

Background - The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information to be exchanged electronically, and the Administrative Simplification Act (ASA), one of the HIPAA provisions, requires standard formats to be used for electronically submitted health care transactions.

The American National Standard Institute (ANSI) developed these, and the ANSI X12N 837 Implementation Guide has been established as the standard of compliance for claim transactions.

A Companion Document is defined as a set of statements, which supplements the X12N 837 Professional Implementation Guide, and it clarifies contractors' expectations regarding data submission, processing, and adjudication.

This instruction revises the X12N 837 Professional Health Care Claim Companion Document and corrects errors and omissions in the Companion Document (previously provided by Change Request (CR) 2900, Transmittal 29, dated December 19, 2003).

This instruction also provides additional language to the Companion Document to cover items not previously addressed. Also note that the Companion Document supplements, but does not contradict, requirements in the X12N 837 Professional implementation guide. A summary of changes to the document includes the following:

• Addition of a new statement indicating "All diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes, pointed to or not, will be rejected;"
• Addition of two negative value statements for the 2400 loop (SV102 and CR102/CR106) which were omitted from the previous document;
• Revision to the calendar date statement, which changes it from "should" to "must;"
• Revisions to the maximum CLM statement which allows your carrier to specify the actual [value] and changes "will" to "will/may;"
• Revisions to ISA06 and ISA08 statements which changes both from "required" to "optional;"
• Correction made to option B of modifier statement; and
• Removal of calendar date statement from 997 section.

The specific language provided in the Companion Document is based on recommendations/decisions made by the Electronic Data Interchange Functional Workgroup (EDIFWG). The EDIFWG consists of members from the Centers for Medicare & Medicaid Services (CMS), Part B contractors, and shared system maintainers.

You have the option of adding specific items not contained in this companion document. However, these items must not contradict any other items in the companion document or in the X12N 837 Professional Implementation Guide.

To view the actual details of the changes for this Companion Document, please see the additional information section for instructions on how to access the official CMS instruction issued to your carrier.

Implementation - The implementation date for this instruction is May 24, 2004.

Additional Information - The official instruction issued to your carrier regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3177 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp. Also, implementation guides for all transactions are available electronically for each transaction at the following Web site: http://www.wpc-edi.com.

HIPAA

Additional Guidelines For Implementing The National Council For Prescription Drug Program (NCPDP) Standards Under HIPAA

Medlearn Matters Article Number: MM3095

Providers Affected - Durable Medical Equipment (DME) Suppliers.

Provider Action Needed

Impact to You - According to the HIPAA implementation guide (IG), Medicare systems must be able to receive the NCPDP HIPAA claim transaction with segments in any order.

What You Need to Know - According to the NCPDP standards, "The receiver cannot force an order of the segments." DME regional carriers (DMERCs) systems then must allow segments to be transmitted in any order as long as the group separator precedes any of the segments.

What You Need to Do - Effective July 1, 2004, the Medicare DMERCs will change their systems to allow segments to be transmitted in any order. In addition, the Medicare systems will be changed effective July 1, 2004, to allow the "MOD" value on certain segments. Be aware of these changes as HIPAA compliancy moves forward.

Background - Effective July 1, 2004, Medicare claims systems, used by DMERCs will allow segments to be submitted in any order including the AM07, AM03, and AM11, in accordance with the NCPDP standard. In addition, the DMERCs must allow the value of "MOD" to be entered in positions 001-003 of the narrative portion of the prior authorization segment indicating the supporting documentation that follows is Medicare modifier information.

Additional Information - Should you have any questions regarding these changes or encounter any problems with claims that follow the NCPDP rules as described above after July 1, 2004, please contact your DMERC at their toll-free number.

If you do not know that number, you may find it at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Gap Filling For X12N 837 COB (Coordination Of Benefits) Claims

When non-HIPPA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 COB transaction, CMS requires that CIGNA Medicare shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999".

When non-HIPPA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 COB transaction, CMS requires that CIGNA Medicare shall gap fill the phone number data element with "8009999999".

Health Insurance Portability And Accountability Act (HIPAA) X12N 837 Professional Health Care Claim Implementation Guide (IG) Editing

Medlearn Matters Number: MM3050

Provider Types Affected - Physicians, practitioners, suppliers, and providers who bill Medicare carriers, including Durable Medical Equipment Carriers (DMERCs).

Provider Action Needed

Impact to You - Affected providers should stop submitting electronic claims with diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant.

What You Need to Know - Providers should note that Medicare systems are strengthening their system edits to assure receipt of HIPAA compliant claims. Effective July 1, 2004, Medicare will reject electronic claims that have diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant.

What You Need to Do - Be sure your billing systems are modified to generate electronic claims that will pass Medicare's HIPAA compliancy edits for diagnosis codes, zip codes, and telephone numbers.

Background - The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information to be exchanged electronically. In addition, one of the HIPAA provisions requires standard formats to be used for electronically submitted health care transactions.

CMS is committed to implementing the 837 COB transaction set per the HIPAA implementation guide (IG), and it recognizes that a change in its systems is needed to:

1) Comply with the 837 Professional IG; and

2) To allow the creation of compliant coordination of benefits (COB) claim files.

To accomplish this, Medicare systems will be changed

to include edits that reject electronic claims that contain:

• Invalid diagnosis codes;
• A dash, a space, or special character in any zip code field; and
• A dash, space, special character, or a parenthesis in telephone numbers.

Implementation - July 6, 2004.

Related Instructions - The ANSI X12N 837 implementation guides are the standards of compliance for claim transactions and are available electronically at: http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

The *Medicare Claims Processing Manual*, Chapter 24 has been updated to include the new Section 40.7.2, Professional Implementation Guide (IG) Edits. This new section is included below:

40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits

The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to or not.

The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain a dash, space, or special character in any zip code.

The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain dashes, spaces, special characters or parentheses in any telephone number.

Medicare Providers: Their Vendors, Clearinghouses, Or Other Third-Party Billers And The HIPAA/Medicare Contingency Plan

Medlearn Matters Article Number: SE0414

Provider Types Affected - All Medicare physicians, providers, and suppliers who use a vendor, clearinghouse, or other third-party billing agent to submit Medicare claims.

Provider Action Needed - Understand the requirements of HIPAA, the Medicare HIPAA contingency plan, its impact, and the need to verify HIPAA compliance by those who bill Medicare on your behalf.

Background - In a recent Medlearn Matters article (see MM2981, which may be found at http://www.cms. hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf), the Centers for Medicare & Medicaid Services (CMS) announced a modification of the HIPAA contingency plan implemented by Medicare on October 16, 2003. Specifically, CMS announced on February 27, 2004, that Medicare would continue to accept claims electronically in a pre-HIPAA format on or after July 1, 2004, but such claims would not be eligible for Medicare payment until the 27th day after receipt, at the earliest. All electronic claims today are eligible for payment at 14 days after receipt.

This modification of the HIPAA contingency plan was intended to give providers additional time to become HIPAA compliant, but **was also a measured step toward ending the contingency plan for all incoming Medicare claims.**

CMS understands that many physicians, providers, and suppliers do not submit claims directly to Medicare, but submit their claims through a third party, such as a billing vendor, clearinghouse or other third-party billing agent. CMS recognizes the importance of these third parties to many providers and the extent to which providers rely on those entities to meet HIPAA requirements in a cost-effective manner with minimal impact on the provider's most important mission, i.e., delivering high quality medical care to those who need such care.

Each provider has made a business decision to use these agents and is therefore best positioned to assess the value of that decision.

CMS urges Medicare providers to understand the following issues, to assess their impact on the provider's business and determine what, if any, steps need to be taken.

Issue # 1- Understand where your vendor, clearinghouse, or other third party biller stands in terms of HIPAA compliance.

Providers are required by statute to achieve compliance and to bill Medicare electronically in a HIPAA-compliant manner. Thus, it is crucial for providers to assure themselves of their third-party partner's readiness. It is especially important to remember that, at the time Medicare's contingency plan is terminated, providers who remain non-compliant will face significant problems.

So, what steps might providers take to assure that they

AND their partners are ready?

• Check with your clearinghouse, vendor, or other third party biller.
• Ask them about their readiness.
• Ask them how they have certified their readiness.
• Make sure they are aware of the Medicare contingency plan and the modification announced on February 27th.
• Ask them if your claims will continue to be eligible for payment on the 14th day after receipt, as of July 1, 2004. Or, will your claims not qualify for such prompt payment from Medicare?
• If your agent indicates that the Medicare contingency plan will affect your claims, ask them when they will correct the problem so your claims are eligible for prompt payment and ask when that will happen.

As stated earlier, CMS's business relationship is with providers and we look to the provider to meet requirements for correct submission of claims in HIPAA compliant formats. We also know that every piece of the process, and every entity involved, must be ready. That is why it is important for providers to question their agents, obtain assurances, and keep abreast of HIPAA developments. Ultimately, the benefits of compliance or the consequences of non-compliance will fall on the provider. Remember that continued timely payment of Medicare claims is closely linked to HIPAA readiness.

Issue #2- Make sure your agent builds on the HIPAA compliance you have achieved.

There have been instances where some third-party billers are taking claims submitted to them by Medicare providers that are HIPAA compliant and then converting them to a non-compliant format before sending them to a Medicare claims processing contractor. Such vendors and agents may be doing this because some of their providers are still not HIPAA compliant and the vendor has chosen to submit non-compliant formats for all their provider customers until all customers are compliant.

These decisions may make good business sense to the vendor, clearinghouse or other third party biller, but their decision may adversely affect providers who are compliant. That will certainly be the case for such claims submitted to Medicare on or after July 1, 2004, when Medicare deems such claims do not qualify for the prompt payment afforded to electronic claims that are HIPAA compliant. At the time Medicare ends its contingency plan, the consequences for non-compliant claims could be even more severe, e.g., a complete stoppage of payments for such claims.

What can providers do? The answer is similar to the one presented for the first issue, i.e., talk with your vendor, clearinghouse, or other third party biller. Ask them about their readiness. Ask them if they are altering your HIPAA compliant input to them into a non-compliant format before sending to Medicare. Ask them to assure you that your claims will remain eligible for payment on the 14th day after receipt on and after July 1, 2004.

As mentioned before, it is the provider's ultimate responsibility to assure they are HIPAA compliant and that means assuring that your claims meet the transaction code set and format standards.

Issue # 3- Understand when your vendor, clearinghouse, or other third party biller will stop accepting non-compliant transactions.

While CMS implemented a contingency plan on October 16, 2003, which allows Medicare providers, suppliers, and other electronic billers to continue sending pre-HIPAA formats, that plan is not binding on other entities. At any time, vendors, clearinghouses, and other third party billers could decide to limit or discontinue supporting pre-HIPAA formats.

We encourage providers and suppliers using a third party entity for sending their electronic claims to work closely with that entity to understand the HIPAA electronic claims requirements. Verify that you are submitting the data required under HIPAA and that your claims are being transmitted in the standard HIPAA format.

In conclusion, the bottom line is that, in order to rotect your interests and ensure **uninterrupted cash flow**, begin immediately to work toward meeting the HIPAA standard requirements.

Additional Information - For additional information on HIPAA, visit the CMS Web site at: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp

Modification Of CMS' Medicare Contingency Plan For HIPAA Implementation

Medlearn Matters Number: MM2981

Providers Affected - All Medicare physicians, providers, and suppliers who submit electronic claims to Medicare.

Provider Action Needed

Impact to You - Effective July 1, 2004, Medicare is modifying its Health Insurance Portability and Account-

ability Act (HIPAA) contingency plan. The modification continues to allow submission of non-compliant electronic claims. However, the payment of electronic claims that are not HIPAA compliant will take thirteen additional days.

What You Need to Know - While the contingency plan remains in place, the submission of non-HIPAA electronic claims to Medicare after July 6, 2004, means that Medicare will take longer to pay such claims.

What You Need to Do - Submit HIPAA compliant claims. If you are already submitting HIPAA compliant claims or will do so on or before July 6, 2004, then this change does not apply to you.

Background - Currently, Medicare pays electronic media claims (EMC) no earlier than the 14th day after the date of receipt (13-day waiting period). Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt (26-day waiting period).

HIPAA requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standard adopted for national use.

The Administrative Simplification and Compliance Act (ASCA) requires claims to be submitted to Medicare electronically, with some exceptions, effective October 16, 2003.

Based on guidance issued by the Department of Health and Human Services to maintain cash flow in the health care industry beyond October 16, 2003 and the fact that only 33 per cent of Medicare's electronic claims were in HIPAA formats as of that date, Medicare implemented a contingency plan to temporarily allow electronic claims to continue to be submitted in a pre-HIPAA format. This was done to provide those members of the healthcare community, who demonstrate a good faith effort to comply, additional time to become HIPAA compliant.

Under the subject modification to the October 16, 2003, contingency plan, those claims submitted electronically **and** in a HIPAA-compliant format will continue to be considered as eligible for Medicare payment on the 14th day after the date of receipt. Claims submitted electronically in a pre-HIPAA format under a Medicare contingency plan, will be considered as eligible for Medicare payment on the 27th day after the date of receipt. **As an example, HIPAA compliant claims received on July 1, 2004, can be** paid as early as July 15, while a claim that is not HIPAA compliant and is received electronically on July 1, 2004, can be paid no earlier than July 28.

Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA formats quickly. This is a measured step toward ending the contingency plan for all incoming claims.

Important Dates - Medicare has instructed its carriers and intermediaries to begin enforcing these rules on July 6, 2004 and the rules will apply to claims received on or after July 1, 2004.

Additional Information - CMS has instructed its Medicare carriers and intermediaries to make available free/low cost software that will enable submission of HIPAA compliant claims electronically. Contact your carrier or intermediary in order to obtain this software at their special EDI number. For those billing Medicare Part A (including hospital outpatient services), a list of these numbers by State is available at: http://www.cms.hhs.gov/providers/edi/anum.asp.

For those billing Medicare Part B, you may find those numbers listed by State at: http://www.cms.hhs.gov/providers/edi/bnum.asp.

For additional information on HIPAA, visit the CMS Web site at: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp.

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the *Medicare Claims Processing Manual*. This can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

To view the actual instruction issued by CMS to your carrier or intermediary, visit: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

Once at that site, scroll down the CR NUM column to 2981 and click on that file.

Update To The Healthcare Provider Taxonomy Codes (HPTCs) Version 4.0

Medlearn Matters Article Number: MM3188

Provider Types Affected - Physicians, suppliers, and providers who bill carriers and Durable Medical Equipment Carriers (DMERCs).

Provider Action Needed - Affected providers should

note that Medicare Contractors (Carriers and DMERCs) must obtain the Health Care Provider Taxonomy Code (HPTC) list, Version 4.0, and use it to validate HPTCs in claims for services on or after May 17, 2004.

Background - The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable the electronic exchange of health information. Since the Health Care Provider Taxonomy Code is a named code set in the 837 Professional Implementation Guide, contractors must validate the inbound taxonomy codes against their internal HPTC tables.

The summary of changes for the Health Care Provider Taxonomy Code list, Version 4.0, is as follows:

Provider Taxonomy Value	Revision
208VP0000X	Modified title from Pain Management to Pain Medicine and added definition
106H00000X	Modified definition
207VM0101X	Added definition

Implementation - The implementation date for this instruction is May 17, 2004, when Version 4.0 of this code set will be used by carriers and DMERCs for claims with dates of service on or after May 17, 2004.

Additional Information - The official instruction issued to your carrier/DMERC regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc_asp

From that web page, look for CR3188 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Secondary Payer

Medicare As The Secondary Payer

Claims submitted for secondary payment consideration should be submitted with the actual charge for the item not the copay or patient responsibility amount. The submitted charge for an item should be the same for the primary payer and for Medicare. Incorrect claim submission may cause an incorrect secondary payment.

Medicare Secondary Payer Fact Sheets

Four new fact sheets on the subject of Medicare Secondary Payer are now available on the Centers for Medicare & Medicaid Services (CMS) Medlearn Web page at: http://www.cms.hhs.gov/medlearn/pubs.asp.

These fact sheets should prove to be very useful in explaining provider/billing clerk responsibilities. The fact sheets are titled as follows:

- Collecting, Submitting, and Updating Beneficiary Insurance Information For Clinical Laboratories
- Complying with Medicare Secondary Payer Requirements
- Collecting, Submitting, and Updating Beneficiary Insurance Information to Medicare
- When Medicare is the Primary Payer

Appeals

Appealing Medicare Overpayments

The DMERC Region D Appeals Department conducts appeals for Medicare overpayments issued by CIGNA Medicare DMERC Region D. When a supplier/beneficiary receives notification that a Medicare overpayment has occurred the parties to the overpayment have appeal rights. We have found that many of these appeals are being submitted to the incorrect department and this delays the appeals process. The first level of appeal for Medicare Overpayments in the amount of $100 or more is a Hearing Officer Hearing. These requests should be sent to:

CIGNA HealthCare Medicare Administration
Attention: Hearing Department
PO Box 22263
Nashville, TN 37202

The first level of appeal for Medicare Overpayments in the amount of $99 or less is a review or redetermination. These requests should be sent to:

CIGNA HealthCare Medicare Administration
Attention: Review Department
P. O. Box 22995
Nashville, TN 37202

Changes In The Appeals Process

As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the first level of appeal for fee-for-service has a new name.

- Starting October 1, 2004, the first level of appeal will be called "Redeterminations" (formerly Reviews).
- Redetermination decisions must be issued within 60 days, as compared to 45 days for a review.
- The format of the letters for partial reversals and affirmations will be improved. They will include more detail about the facts involved the case and a clearer explanation of further appeal rights. In cases where the entire allowed amount is approved as a result of the redetermination no letter will be issued. The adjustment will appear on the supplier's Medicare Remittance Notice.

Submitting Additional Documentation With The Review Request

The DMERC Review Department makes every effort to provide a thorough analysis of every request we receive. It is important that we have ALL of the facts available concerning the issues involved. If you submitted additional information with your original claim please note this on your review request or include that information with the review request. All medical documentation must be signed and dated by a health care professional. If the beneficiary has signed an Advance Beneficiary Notice, please submit a copy along with your review request.

The following are examples of additional documentation that may be sent with the review request:

Surgical Dressings

- A **dated** wound evaluation that gives the stage, drainage and size of the wound. It should be dated within 30 days of the date of service in question.
- If you are billing a Not Otherwise Classified (NOC) code, we need a detailed description of the item such as the product name and product number.
- A detailed written order from the patient's physician.

Urologicals

- Nurses notes and patients daily care records. If the patient requires additional quantities of catheters the reason for the need must be documented.
- Documentation from the patient's doctor providing information about the patient's medical condition including episodes of pyuria, fevers and/or urinary tract infections.

Wheelchairs, POVs, Attachments and Accessories

- The Certificate of Medical Necessity.
- The Physical or Occupational Therapist's notes.
- Medical records which explain the need for the wheelchair and each individual accessory.
- Manufacturer's name and product number, invoice/ suggested retail price.
- Description of the patient's routine activities outside the home.
- For code K0005 - Describe features needed compared to the K0004 or K0003 wheelchair.
- If billing for K0108 (Wheelchair Component Or Accessory, Not Otherwise Specified), include description of the item, product name, product number, and medical necessity for the item.

Prosthetics and Replacement Sockets

- A new order signed by the doctor.
- Measurements of residual limb changes.
- Medical documentation that explains the need for socket replacements or new prosthetic. This information should include any weight changes, level of activity, length of time since amputation, number of sock plies used.

Orthotics

- Treatment plan from the doctor and supplier.
- Documentation about the patient's condition which explains the need for new or replacement orthotics.

Lymphedema Pumps

- The Certificate of Medical Necessity.
- Additional documentation that describes the location of the lesion(s), any other treatments tried or the reasons other treatments could not be tried.

Multiple Ventilators

- Medical records or documentation to demonstrate the medical need for more than one ventilator.

Tracheal Suction Catheters

- Documentation describing the patient's condition and that of the tracheostomy site.
- The medical reasons for any increase in catheter usage.

Enteral Formula (Category IV and V Nutrients)

- Lab results
- Test results

Documentation that demonstrates the patient's condition on the Category I nutrient as opposed to the Category IV or V nutrient over a period of time.

Parenteral Formula

- Discharge Summaries
- Operative reports
- Fecal Fat tests
- Evidence of failed tube trails and significant malnurishment

Air Fluidized Beds

- The Certificate of Medical Necessity
- Current wound evaluation
- Additional documentation that outlines patient's condition, description of other treatments tried, the level of bed confinement and the possibility of institutionalization in the absence of the bed.

Support Surfaces

- The Certificate of Medical Necessity
- A statement from the ordering physician

Infusion Pumps for Dobutamine, Milrinone and Dopamine

- Hospital Discharge Summary
- Inotropic data form (Supplier Manual, Chapter 9, EIP)
- Cardiac Catheterization report

Same or Similar Equipment Denials

- The Certificate of Medical Necessity, if applicable
- Physician's order
- Signed pick up and delivery tickets
- A detailed outline of events (who provided what and when)

Break In Service Denials

- A description of the patient's prior medical condition which necessitated the previous item;
- A statement explaining when and why the medical necessity for the previous item ended; and
- A statement explaining the patient's new or changed medical condition and when the new need began.

Forgotten KX Modifier

- Documentation substantiating the beneficiary met criteria based on the appropriate policy.

Miscellaneous

Are Your Claims Being Rejected?

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare *unless* you meet certain "exceptions" described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the guidelines below.

In cases where a paper claim needs to be filed, the CMS-1500 claim form should be completed accurately. Instructions for completing the entire claim form can be found in the *DMERC Region D Supplier Manual*, Chapter 6, pages 36 - 43. The following items from the CMS-1500 form have been identified as the items most likely to be completed inaccurately.

1. **Item 1a and 2 -** The Beneficiary's Medicare number must be entered on the CMS-1500 form to insure proper processing of their claim. Always check the Medicare Insurance Card for beneficiary information.

a. Enter the number from this card in item 1a.
b. Enter the name as shown on this card in item 2.

2. **Item 9 -** This item should only be completed if all of the following are true:

a. You are a participating provider.
b. The beneficiary has a Medigap company as their Medicare supplement.

If the above criteria are met, enter the following in item 9a-d:

a. Enter the word "Medigap", "MG" or "MGAP".
b. Enter either the OCNA number OR the Company name, address, city, state and zip code. A list of Medigap OCNA numbers can be found in the supplier manual, Chapter 7, pages 4-11.
c. Enter the policy number.
d. Item 13 must be signed by the beneficiary.

The claim will only crossover to the Medigap company if all the above criteria are met. Leave item 9 blank if any of the above information is not available.

3. **Item 19 -** Specific information should be entered in

item 19 or on an attachment. This includes:

a. A description of items billed using a not otherwise classified code (NOC), or
b. If more than 4 modifiers need to be billed on a line, enter KB for DME upgrades or 99 for other situations to the 4th modifier position in item 24D. Enter the line number and any modifier that the KB or 99 represent in block 19, or
c. Cataract surgery date, or
d. Dates needed for payment on the continuous passive motion (CPM) device.

4. **Item 24D -** This block should only include procedure codes and modifiers. Any code description or other needed information should be included in item 19 or on an attachment.

5. **Item 33 -** The name and address of the company should be entered in this block. To ensure proper payment always include the provider identification number (PIN) also referred to as the supplier number. Failure to include the correct PIN could result in incorrect payment or the return of your claim.

Proper completion of the CMS-1500 form will help expedite the processing of your claim. If your claim is returned as unprocessable a new CMS-1500 form must be submitted for processing.

Remember, beginning October 16, 2003, all claims should be submitted electronically unless you met the criteria for exemption.

CMS Creates Additional Supplier-Specific Web Pages

The Provider Communications Group within the Center for Medicare Management has created additional provider and supplier-specific Web pages, and also has new Web page addresses and provider Web tools on the Centers for Medicare & Medicaid Services' (CMS) Web site (http://www.cms.hhs.gov/). CMS wants to ensure providers and health care practitioners have quick access to accurate Medicare program information. In keeping with this goal, the supplier-specific Web page listed below is a one-stop resource focused on the informational needs and interests of Medicare providers, including physicians and other practitioners.

The supplier-specific Web page can be accessed from http://www.cms.hhs.gov/suppliers.

Specialized information on these one-stop resource pages includes links to Federal Regulations and Notices, Transmittals/ Change Requests, and Frequently Asked Questions. General information includes links for Coverage, Coding, Program Integrity/ Medical Review and a wealth of other subjects that would be of interest to all audiences. Each page also has a *Highlights* section to emphasize important and timely information such as pertinent regulations, instructions, or conferences. Providers, physicians, and suppliers can now go to http://www.cms.hhs.gov/mailinglists to subscribe to ListServ for various Medicare audiences or categories.

New provider/supplier Web pages include:

http://www.cms.hhs.gov/providers/emtala - **Emergency Medical Treatment & Labor Act (EMTALA) —** Content includes Policy, Regulations, Manuals, Frequently Asked Questions and more.

http://www.cms.hhs.gov/providers/esrd.asp - **End-Stage Renal Disease (ESRD) Information Resource —** Content includes Regulations, Coverage, Billing, Demonstrations, CROWN, Forms, Network Organizations, Public Use Files, Publications, Dialysis Facility Compare, and more.

http://www.cms.hhs.gov/providers/pair - **Practice Administration Information Resource for Medicare —** Content includes up-to-date information and tools as they relate to Administrators, Coders, Billing Personnel, and others outside the traditional provider role.

http://www.cms.hhs.gov/suppliers/asc - **Ambulatory Surgical Centers (ASC) –** Content includes information on Enrollment/ Participation, Payment Rates, Regulations, and more.

http://www.cms.hhs.gov/providers/fqhc - **Federally Qualified Health Centers (FQHC) —** Content includes Regulations, HIPAA, Enrollment, Frequently Asked Questions, Forms, Manuals, Publications and more.

http://www.cms.hhs.gov/suppliers/dmepos - **Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) —** Content includes Billing Instructions, Coding, Payment, Medical Review information and more.

http://www.cms.hhs.gov/providers/hha - **Home Health Agencies (HHA) —** Content includes Regulations, Coding, Billing, Outcome and Assessment Information Set (OASIS) and Outcome-Based Quality Improvement (OBQI), and more.

http://www.cms.hhs.gov/providers/hospiceps - **Hospice —** Content includes Certification, Educational Articles,

Frequently Asked Questions, Research and Statistics information and more.

http://www.cms.hhs.gov/providers/ipfpps - **Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) —** Content includes useful information related to the development of a PPS for Medicare inpatient psychiatric services, including Background and Coding information, the proposed Regulation and Assessment Tool and more.

http://www.cms.hhs.gov/suppliers/mammography - **Mammography Services –** Content includes Coding, Policies/ Regulations, helpful Resources and more.

http://www.cms.hhs.gov/providers/rh - **Rural Health Clinics —** Content includes Regulations, Enrollment, Coverage, Publications, Forms, Manuals, and more.

http://www.cms.hhs.gov/providers/snfpps - **Skilled Nursing Facilities (SNF) PPS —** Content includes Regulations, Publications, Rates and Indices, MDS, Swing Bed, Frequently Asked Questions and more. Additional pages are currently under development for anesthesiologists, surgeons and the Indian Health Service.

Consolidation Of The Claims Crossover Process: Additional Common Working File (CWF) Functionality

Medlearn Matters Article Number: MM3109

Provider Types Affected - All Medicare providers.

Provider Action Needed - Medicare physicians, suppliers, and providers should note that this instruction communicates changes to the existing Medicare claims crossover process. CMS is implementing a new initiative known as the "Coordination of Benefits Agreement (COBA) consolidated crossover process." This article provides guidance on the new COBA crossover strategy, including a new claim-based Medigap and Medicaid crossover process to be implemented by Medicare carriers and DMERCs on October 4, 2004. It is especially important to understand that the new claim-based COBA IDs being issued by CMS to Medigap insurers and State Medicaid Agencies must be submitted on incoming claims in certain defined instances, as explained later in this article.

Background - The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. The program offers an automatic crossover service to other insurers, or trading partners, that may pay benefits after the Medicare claim has been processed. The trading partner is charged a fee-per-claim that is crossed by Medicare. COB trading partners include:

- Medicare supplemental insurers (i.e., non-Medigap plans);
- Title XIX State Medicaid Agencies; and
- Medigap insurers.

In order to better service its customers, CMS is streamlining the claims crossover process and is consolidating the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC).

As part of this streamlined process, COB trading partners, who are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare carriers and intermediaries. Instead, each COB trading partner will:

- Enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor (COBC); and
- No longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers, nor receive numerous crossover files. They will instead submit one eligibility file periodically and will regularly receive a consolidated file of claims data for those eligibles.

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process and more effective processes for Medicare providers to receive claim payments that are secondary to Medicare benefits. In addition, the revised COBA process will ensure that CMS fulfills the requirements imposed by the HIPAA ANSI-X12 835 (Electronic Remittance Advice (ERA)) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers.

Eligibility-Based Crossover Process - As previously mentioned, national COBAs will now be executed with the COBC by the trading partners and trading partners will send COB eligibility files to the COBC. Trading partners that provide eligibility files will be assigned COBA IDs to facilitate the crossover process.

For an eligibility file-based crossover, the COBA ID of the trading partner, along with all other eligibility file data elements associated to an individual beneficiary, will be stored in Medicare's Common Working File (CWF) in the recently established Beneficiary Other Insurance (BOI) auxiliary record. CWF will also house the COBA Insurance file that will contain specific information associated to the trading partner that is identified on the BOI auxiliary record. As Medicare claims are processed, CWF will be equipped to apply each COB trading partner's claims selection criteria against the Medicare claims and provide information to the Medicare carrier or intermediary to enable those entities to place appropriate crossover claims information on the HIPAA ANSI X12N 835 Electronic Remittance Advice sent to providers and suppliers.

Claim-Based Crossover Process - For those Medigap and Medicaid insurers that do not provide COB eligibility files identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented by October 4, 2004. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC. Medicare providers and suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs and will be responsible for entering the unique claim-based COBA IDs on each claim submitted to Medicare to initiate the crossing over of claims to the Medigap or Medicaid insurer for supplemental payment to the provider or supplier.

Through this instruction, Medicare claims processing systems will also be modified to house Medigap and Medicaid claim-based COBA IDs and the associated Medigap or Medicaid information necessary for the Medicare carrier or DMERC to prepare an ERA and send the claim to the COBC to cross to the Medigap or Medicaid insurer. The Part B or DME provider or supplier is required to include a claim-based COBA ID on incoming Medicare claims where:

• The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS' COBA claim-based ID listing;
• The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
• The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

Implementation - July 6, 2004

Because of this instruction's impact on providers and suppliers, Carriers and DMERCs will not be required to implement the COBA claim-based crossover requirements described in this instruction until October 4, 2004. Effective October 4, 2004, all participating Part B and DME providers and suppliers will cease including the Carrier or DMERC-issued Medigap or Medicaid ID on incoming claims. Instead, they will begin to include the claim-based COBA ID, which will be assigned by Medicare's Coordination of Benefits Contractor (COBC), on incoming claims. When Part B or DME providers or suppliers check the claim-based COBA ID listing and locate the beneficiary's identified Medigap plan, they shall include the Medigap claim-based COBA ID on the incoming claim if: 1) the provider or supplier participates in the Medicare Program; and 2) the beneficiary assigns (or has assigned) his/her rights to benefits to the provider or supplier. When Part B or DME providers or suppliers that participate in the Medicare Program check the claim-based COBA ID listing and locate the State Medicaid Agency that pays benefits for the beneficiary, they shall include the Medicaid claim-based COBA ID on the incoming claim.

As of October 4, 2004, CMS will require participating Part B and DME providers and suppliers to include the CMS-issued Medigap or Medicaid claim-based COBA ID on their submitted claims to Medicare if they wish to have their patients' Medicare claims crossed over to the Medigap or Medicaid insurer that does not supply an eligibility file for their insureds. (Section 70.6 of Chapter 28 of the *Medicare Claims Processing Manual* (Pub 100-04) has complete details concerning this requirement as well as other coordination of benefits procedures.)

Additional Information

You can find the Centers for Medicare & Medicaid Services (CMS) Program Manuals Index at the following CMS Web site: http://www.cms.hhs.gov/manuals/cmsindex.asp.

Also, the *Medicare Claims Processing Manual* (Pub 100-04) is located at the following CMS Web site: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

Chapter 28 of that manual may be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104c28.pdf. Additional Coordination of Benefits information can be found at: http://www.cms.hhs.gov/manuals/105_msp/msp105c04.pdf.

The Consolidation Of The Claims Crossover Process: Smaller-Scale Initial Implementation

Medlearn Matters Article Number: MM3218

Providers Affected - All Medicare physicians, providers, and suppliers.

Provider Action Needed

In recent instructions to Medicare carriers, including Durable Medical Equipment Carriers (DMERCs) and Fiscal Intermediaries (FIs), the Centers for Medicare & Medicaid Services presented the requirements for a redesigned process for coordination of benefits activities. (For an explanation of these requirements/instructions, see Medlearn Matters article MM3109.)

In CR 3218, CMS is advising the carriers, FIs, and DMERCs that the implementation schedule is being altered and some requirements have changed. Providers need to be aware of how these changes, as described below, may affect them.

The key message is that the impact of this change on providers is delayed from July 6 until further notice.

Background - The Centers for Medicare & Medicaid Services (CMS) is starting the consolidation of the claims crossover process by beginning with a smaller-scale implementation on July 6, 2004. Through this instruction, CMS announces which portions of Transmittal R-98 (Change Request (CR) 3109) are:

- Still applicable;
- Which requirements have changed; and
- Which requirements are being moved to the October 4, 2004, systems release or to another future release.

Details regarding the requirements that have changed, and which are being moved to the October 4, 2004 systems release or to another future release, are listed in CR3218, which can be found at the CMS Web site address that is included in the Additional Information section of this article.

A key change is that the entire process will not be implemented on July 6, 2004, as mentioned in CR3109 and Medlearn Matters article MM3109.

Instead, a pilot test will be conducted from July 6, 2004 through October 1, 2004, when approximately eight Coordination of Benefits Agreement (COBA) trading partners will participate as beta-testers in a parallel production crossover environment.
During the parallel production period, the eight COBA trading partners will continue to receive crossover claims from Medicare contractors and will also receive crossover claims as part of the COBA process.

In light of CMS' decision to implement the COBA crossover consolidation project on a smaller scale within a parallel environment, Medicare carriers/FIs/DMERCs will continue to follow their current processes for the printing of Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) crossover messages throughout the period from July 6, 2004 to October 1, 2004.

Medicare contractors will also continue to charge all trading partners to whom they cross Medicare claims. During the parallel production period, CMS' Medicare Coordination of Benefits Contractor (COBC) will **not** be charging the trading partners that participate in the COBA beta-site testing for claims that it crosses to them.
The eligibility-based crossover process will begin to be implemented on a larger scale on October 4, 2004. Also on October 4, 2004, the initial eight COBA beta-site testers will be converted to full production and will begin to be charged for claims that the COBC crosses over to them.

CMS' claim-based COBA crossover process is being delayed until a future systems release**.**

This process previously had a major impact on the provider community as of October 2004 and that will not occur in October 2004 as previously planned.

Implementation

The implementation date for this instruction is July 6, 2004. This means that only those participating in the pilot phase are affected on that date. All other trading partners will not be affected until October 1, 2004, at the earliest. Additional instructions will be issued as new implementation dates are established for moving from the pilot phase to full implementation.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Also, Transmittal R-98, Change Request 3109, Consoli-

dation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality, dated February 6, 2004, can be found at the following CMS Website: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3109.pdf.

Change Request 3218 supercedes CR 3109 and deletes the impact on provider requirements listed in requirements 20 and 21 in CR 3109. Consolidated claim-based crossovers have been delayed until further notice. The claim-based crossover process remains unchanged at the Medicare contractors.

NOTE: New Medicare Crossover Process - The previous articles for Change Request 3109 and 3218 outline the changes being initiated for crossing Medicare claims to the secondary payer. One of the requirements for these Change Requests is that Medicare/Medicaid claims be processed as assigned claims.

Effective October 1, 2004, claims filed for Medicare/Medicaid beneficiaries must be filed as assigned.

DMECs – Online Coding Assistance From The SADMERC

The SADMERC introduces DMECS (Durable Medical Equipment Coding System). DMECS is an online application that will provide Healthcare Common Procedure Coding System (HCPCS) coding assistance and national pricing information 24 hours a day. DMECS is designed to help Medicare providers and suppliers quickly classify durable medical equipment, prosthetics/orthotics, and supplies (DMEPOS) by combining information from a variety of sources to make HCPCS coding determinations for claim submission to the DMERCs easier. The first phase of DMECS will include a HCPCS and fee schedule look-up with capabilities to print or download information. Future enhancements will include SADMERC Classification Lists, sample product pictures, and a coding navigator tool that categorizes and combines HCPCS codes in a format that allows you to easily determine how to code your product.

Please watch the SADMERC's Web site for DMECS, which will be an option from the Web site's menu. You may access Web site by selecting SADMERC from the Palmetto GBA home page at www.palmettogba.com. Future release information will be available under the 'What's New' section. Your feedback is vital to the success of this tool. Please e-mail your feedback to SADMERC by selecting "Contact Us" on their Web site.

Extended Repayment Plan

A debtor is expected to repay any overpayment as quickly as possible. If it cannot refund the total overpayment within 30 days after receiving the first demand letter, it should request an extended repayment plan (ERP) immediately. However, an ERP request may be received and shall be reviewed at any time the overpayment is outstanding. The provider must explain and document its need for an extended (beyond 30 days) repayment plan. A repayment plan may be established to recover all or part of an overpayment. Any approved ERP will run from the date of the initial demand letter.

A written request must be submitted that refers to the specific overpayment for which an extended repayment is being requested. This request must detail the number of months requested, indicate the approximate monthly payment amount (principal and interest, if possible), and include the first payment.

Please provide the following when requesting an ERP:

If sole proprietor:

• Complete form CMS – 379 (copy included in the back of this newsletter)

• Attach income tax statements from the most recent calendar year

If entity other than a sole proprietor:

• Amortization Schedule- this schedule shall contain the proposed repayment schedule, including length of schedule, dates of payment, and payment amount broken down between principal and interest for the life of the schedule

• Balance sheets - the most current balance sheet and the one for the last complete Medicare cost reporting period or the most recent fiscal year (preferably prepared and certified by the provider's accountant).

NOTE: If the time period between the two balance sheets is less than 6 months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last two complete Medicare reporting periods (providers that file a cost report) or last two complete fiscal years.

• Income statements - related to the balance sheets (preferably prepared by the provider's accountant).

CMS suggests that both the balance sheets and in-

come statements include the following statements:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OF ADMINISTRATOROF PROVIDER(S)
(For physicians/suppliers, "CERTIFICATION BY OFFICER/OWNER OF DEBTOR(S))

I HEREBY CERTIFY that I have examined the balance sheet and income statement prepared by _____and that to the best of my knowledge and belief, it is a true, correct, and complete statement from the books and records of the provider.

Signed
Officer or Administrator of
Provider(s)
Title

Date

(For physicians/suppliers: Signed Officer or Owner of Debtor(s) Title)

• Statement of Sources and Application of Funds - for the periods covered by the income statements (see CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual,* Chapter 4, Section 50.3, Exhibit 2 for recommended format).
• Cash flow statements - for the periods covered by the balance sheets (see CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual,* Chapter 4, Section 50.3, Exhibit 3 for recommended format). If the date of the request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement should be provided for all months between that date and the date of the request.

In addition, whether or not the date of the request is more than 3 months after that of the most recent balance sheet, a projected cash flow statement should be included for the 6 months following the date of the request.

• Projected cash flow statement - covering the remainder of the current fiscal year. If fewer than 6 months remain, a projected cash flow statement for the following year should be included. (See CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual,* Chapter 4, Section 50.3, Exhibit 3 for recommended format.)

• List of restricted cash funds - by amount as of the date of request and the purpose for which each fund is to be used.
• List of investments - by type (stock, bond, etc.), amount, and current market value as of the date of the report.
• List of notes and mortgages payable - by amounts as of the date of the report, and their due dates.
• Schedule showing amounts - due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet—such as Accounts Receivable, Notes Receivable, etc
• Schedule showing types - and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.

% Loan Applications - Requests for extended repayment of 12 months or more. Have the debtor include at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.

All financial records must be for the business participating in the program. They should not be for the owner if the business is a partnership or a corporation. If the financial aspects of the business are managed by an outside facility, the provider's individual financial records must still be submitted as well as the financial records of the outside facility.

If a debtor is unable to furnish some of the documentation, it should fully explain why it is unable to.

Frequency Limitations For Darbepoetin Alfa (Trade Name Aranesp) For Treatment Of Anemia In End Stage Renal Disease (ESRD) Patients On Dialysis

Medlearn Matters Article Number: MM2984

NOTE: The instructions in this article are applicable to Renal Dialysis Facilities. DMERCs do not have jurisdiction for services related to Method I dialysis and is publishing this article as informational only.

Provider Types Affected - Renal Dialysis Facilities.

Provider Action Needed
Impact to You - Medicare is instituting new frequency limitations for treatment of ESRD patients on dialysis with Darbepoetin Alfa (trade name Aranesp).

What You Need to Know - Be aware of these frequency limitations to assure correct and timely payment for services supplied to Medicare patients.

What You Need to Do - Make sure you understand the changes effective for services provided on and after April 1, 2004 for the frequency limitations on Darbepoetin Alfa for ESRD.

Background - Section 1881(b) (11) (B) of the Social Security Act states that payment will be provided for erythropoietin when a patient diagnosis is ESRD. Darbepoetin Alfa, a new erythropoietin-like product, differs from Epoetin Alfa by the addition of two carbohydrate chains, which lengthens the biologic half-life. This change affects how often the biological can be administered and results in a decreased dosing schedule for Darbepoetin Alfa by comparison to Epoetin Alfa.

Additional Information - This notice establishes frequency limitations for darbepoetin alfa, and also reiterates the frequency limitations for Epoetin Alfa (trade name EPO) will remain the same. You can refer back to CR2963 for the payment guidelines on Darbepoetin Alfa (trade name Aranesp). That CR may be found at: http://www.cms.hhs.gov/manuals/pm_trans/R39OTN.pdf

Please note that this notice does not apply to physicians' payments for Aranesp or EPO; those payments are established in the Drug Payment Limits Pricing File, set by the Medicare Prescription Drug, Modernization, and Improvement Act of 2003.

According to its FDA-approved labeling, Darbepoetin Alfa is to be given once a week, up to a maximum of five times for a calendar month (30/31 days). Coverage rules for Darbepoetin Alfa are the same as Epoetin Alfa for ESRD-related anemia.

To view the actual change request related to this article (CR2984), go to: http://www.cms.hhs.gov/manuals/pm_trans/R8BP.pdf

Guidelines For Filing Paper Claims

*** Failure to follow these guidelines could cause a delay in processing, denial of the claim, or affect payment accuracy. ***

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare *unless* you meet certain "exceptions" described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the following guidelines.

1. Do not submit black CMS-1500 forms. This includes submitting copies or carbon copies. Always submit a RED CMS-1500 form.

2. Do not write or stamp information in RED ink. Information in red will not show up on the image and will not be available during processing.

3. Do not use light print or a Dot Matrix printer which causes broken lines. Check to make sure the ink is dark. Also, laser or inkjet printers are preferred.

4. Do not use small font type and size. For best processing results we recommend font type Lucida Console and size 10.

5. Do not use handwriting. It may be too light or simply unrecognizable.

6. Do not highlight items on the CMS-1500 form or attachments. This will cause the claim to be illegible which slows down the processing of the claim.

7. Do not use stamps or stickers within the body of the claim. If you must use a stamp or sticker, put it at the top of the claim within the blank area.

8. Do not leave block 11 blank. If no primary insurance exists, put NONE in the field.

9. Do not use extra verbiage within the body of the claim. If you must put extra verbiage on the claim, use block 19 or an attachment.

10. Do not put a description next to the diagnosis code in block 21. All that is needed is the ICD-9 alpha/numeric diagnosis code.

11. Do not submit more than four diagnosis codes within block 21.

12. Do not submit more than one diagnosis pointer in block 24e. Only the first pointer will be used for processing.

13. Do not submit more than six service lines within block 24.

14. Do not put a description of the procedure codes or

times/units underneath the line item in blocks 24a – 24k. It is not needed and may cause processing errors.

15. Do not place the number of units/days in block 24g too close to the charges in 24f. This may cause the units/days to be read as a part of the submitted charges and the number of units/days to default to 1. Right justifying the days/units in block 24g will give more space between the two fields.

16. Do not put a phone number on the first line of block 33. Submit the phone number below the provider's name and address.

17. Do not omit the zip code in block 33. This block is used as the mailing address when a claim is returned.

18. Do not change the size of EOBs or copy them across to two pages. This may cause your EOB to be illegible.

19. Submit claims to P.O. Box 690 only.

As an alternative to paper claims, you may want to consider Electronic Media Claims (EMC). Electronic billers receive faster payment, save on postage, and have less paper shuffle, saving valuable time. For more information, contact our EDI department at 1-866-224-3094.

New Medicare-Approved Drug Discount Cards And Transitional Assistance Program: A Summary For Physicians And Other Health Care Professionals

Medlearn Matters Number: SE0422

Provider Types Affected - Physicians and other health care professionals

Provider Action Needed - Understand the Medicare-Approved Drug Discount Cards and Transitional Assistance Program that begins in 2004 to help Medicare beneficiaries save on prescription drugs.

Background - As part of the Medicare Modernization Act of 2003 (MMA), the Medicare-Approved Drug Discount Cards and Transitional Assistance Program begins in 2004 to help Medicare beneficiaries save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help Medicare beneficiaries save on prescription drug costs. This article is designed to give an overview of the new Medicare-Approved Drug Discount Cards and Transitional Assistance Program. It will also explain where you may refer Medicare patients for information on selecting and enrolling in the drug discount card that best suits their needs.

Medicare-Approved Drug Discount Cards

- Open enrollment started in May 2004
- Available to qualified beneficiaries regardless of income
- Represent a variety of discount and drug options from private companies
- Available to beneficiaries eligible for or enrolled in Medicare Part A or enrolled in Medicare Part B, **unless** receiving outpatient prescription drug coverage through State Medicaid programs
- May charge an annual enrollment fee of no more than $30, which may be paid by Medicare for some low-income beneficiaries
- Do **not** require that beneficiaries purchase discount drugs through mail-order pharmacies
- Provide beneficiaries the ability to use their discount cards in pharmacies near their homes.

Transitional Assistance Program

Beneficiaries with the greatest need will have the greatest help available to them. Individuals with an annual income in 2004 of no more than $12,569 if single or $16,862 if married, and individuals receiving help from their state in paying their Medicare premiums or cost sharing, may qualify for a $600 credit on their discount card to help pay for prescription drugs. These income limits change every year. Residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Where Do I Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs?

In addition to the Medicare-approved drug discount cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers' discount programs may be a better fit for certain individuals.

Medicare recognizes that physicians and other health care professionals have limited time available to counsel patients. The following resources are available to

help individuals with questions about the Medicare-approved drug discount cards:

The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center

This Call Center is available 24 hours per day and 7 days per week. It connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Beneficiaries may request a copy of their individualized price comparison results. TTY users should call 1-877-486-2048.

The Prescription Drug and Other Assistance Programs Website at Medicare.gov www.medicare.gov/AssistancePrograms/home.asp

For beneficiaries who use the Internet, this site features eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs.

Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card www.medicare.gov

This resource provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

State Health Insurance Counseling and Assistance Programs (SHIP)

Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit **www.medicare.gov/Contacts/Related/Ships.asp** on the Web.

Information Resources for Physicians and Other Health Care Professionals

• Download a free patient-education brochure at **www.medicare.gov** (or call 1-800-MEDICARE to order a limited number of free copies).

• Read The Medicare-Approved Drug Discount Cards and Transitional Assistance Program - A Brochure for Physicians and Other Health Care Professionals at **www.cms.hhs.gov/medlearn**.

• Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of physicians, nurses, and allied health professionals. Visit **www.cms.hhs.gov/opendoor** for further details.

• Visit **www.cms.hhs.gov/medicarereform** for the latest information on MMA.

• Contact your carrier for information by using the toll-free provider lines. Visit **www.cms.hhs.gov/medlearn/tollnums.asp** for your carrier's toll-free number.

New Part B Annual Deductible

Medlearn Matters Number: MM3121

Providers Affected - Physicians, suppliers, and providers.

Provider Action Needed - Physicians, suppliers, and providers should note that, effective January 1, 2005, the Supplementary Medical Insurance (SMI) or Medicare Part B deductible will be $110. These providers should assure that their billing processes are adjusted to handle this change in the Medicare Part B deductible.

Background - Medicare Part B helps beneficiaries pay for physician's services, diagnostic tests, ambulance services, durable medical equipment, and other health services, and the beneficiary is responsible for the first $100.00 deductible of Medicare Part B approved charges each calendar year, i.e. their annual deductible. For calendar years 1991 through 2004, the Medicare Part B annual deductible has been $100.

Beginning in 2005, the Medicare Part B deductible will be $110 (based on Section 629 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA)).

Implementation - This change is effective on January 1, 2005 and the implementation date in Medicare claims processing systems will be January 3, 2005.

Related Instructions - The Medicare General Information, Eligibility, and Entitlement Manual Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations, Section 20 (Supplementary Medical Insurance (SMI) (Part B), Subsection 20.2 (Part B Annual Deductible) has been revised and is included below with

changes bolded and italicized.

20.2 - Part B Annual Deductible - (Rev.) In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

• ***For 2005, and until further notice, the deductible is $110.***
• ***From 1991 through 2004***, the deductible is $100.
• From 1982 through 1990, the deductible was $75.
• From 1973 through 1981, the deductible was $60.
• From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. ***Non-covered*** expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services that are not subject to the deductible cannot be used to satisfy the deductible.

Additional Information - You can find the Centers for Medicare & Medicaid Services (CMS) Program Manuals Index at the following CMS Website: http://www.cms.hhs.gov/manuals/cmsindex.asp

Also, the Medicare General Information, Eligibility, and Entitlement Manual is located at the following CMS Website: http://www.cms.hhs.gov/manuals/101_general/ge101index.asp

Offset Option Available On The DMERC Supplier IVR

CIGNA Medicare Region D DMERC has enhanced the Supplier IVR to include offset information. In order to obtain offset information, the supplier number and the FCN number as shown on the Medicare remittance notice is needed. The offset option includes the claim detail information of the original overpayment and/or the original overpayment letter date and current offset balance amount. The claim detail information includes the Medicare number, overpayment amount and date(s) of service for each claim involved in the original overpayment. Claim detail information is available for FCNs that contain 34 claims or less. If the FCN contains more than 34 claims or no claim detail information is available for the FCN entered, a copy of the original overpayment letter may be obtained by faxing a request to 615.782.4623.

Order Influenza Vaccine Now

NOTE: The DMERC does not have jurisdiction for injections administered in the physician's office and is publishing this as informational only.

In order to ensure the availability of influenza vaccine for administration early in the Fall of 2004, physicians and providers should begin to order supplies of influenza vaccine immediately. Last year, large numbers of cases of influenza began to appear in October, and activity was widespread. Anticipation of increased demand for vaccine in the Fall of 2004 makes it imperative that physicians and providers who care for Medicare beneficiaries and others at high risk for complications from influenza begin to prepare for the 2004-2005 influenza season immediately.

While the recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 changed the Medicare payments for many covered drugs and biologicals, the basis for Medicare payment of influenza vaccine will continue to be 95% of the average wholesale price.

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

• Inform providers about new developments in the Medicare program;
• Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
• Ensure that providers have time to react and prepare for new requirements;
• Announce new or changing Medicare requirements on a predictable schedule; and
• Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update ListServ (electronic mailing list) at http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1.

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate. We encourage you to bookmark this Web site and visit it often for this valuable information.

Region D Publications Distribution Options

CIGNA Medicare is pleased to offer suppliers more options for receiving quarterly publications. Suppliers with multiple sites and multiple supplier numbers may now eliminate publication distribution to some or all of their sites by opting to have one CD-ROM mailed to their corporate address. The corporate office may then disseminate the publications to the site locations. The CD-ROM will be mailed to the "Mail To" corporate address on the supplier enrollment application.

Multiple-site suppliers may choose to eliminate all supplier numbers with the same "Mail To" address from the CD-ROM mailing. This request will include all supplier numbers issued thereafter that have the same "Mail To" address. Secondly, multiple-site suppliers may choose to eliminate the CD-ROM mailing only for the supplier numbers listed. This request would not include any newly issued supplier numbers unless a new request for CD-ROM elimination is submitted.

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.com) and CD-ROM. The CD-ROM is mailed to all suppliers with billing activity for the previous 12 months unless the supplier designates an alternate distribution as described below.

Supplier publications distribution options are as follows:

• Opt-out of the CD-ROM distribution – suppliers will receive a paper copy of the *DMERC Dialogue*.

• Opt-in – suppliers that previously opted-out may return to receiving the CD-ROM.

• Eliminate CD-ROM distribution to multiple sites – the CD-ROM will be mailed to the supplier's corporate address.

The DMERC Region D Publications Designation Form is a new form included in this issue that will allow suppliers to designate the method of publications distribution they prefer. This form replaces the previous Request for CD-ROM Alternative and Request for DMERC Dialogue CD-ROM forms and adds an additional option for publications distribution for multiple-site suppliers.

Supplier requests for an alternate distribution may be submitted via the DMERC Region D Publications Designation Form or by submitting a written request on the supplier's letterhead. The written request must contain all information included on the form. Requests must be submitted to:

CIGNA Medicare
Communications Department
Two Vantage Way
Nashville, TN 37228

Or by fax: 615.782.4445

Requests must be submitted no later than July 1st for distribution of the Fall 2004 publication. Requests received after that date will be honored beginning with the next scheduled publication.

Reporting Address And Other Changes To The National Supplier Clearinghouse (NSC)

Suppliers must notify the National Supplier Clearinghouse (NSC) of **any changes** that occur after the initial application is filed, including changes to their "Mail to" and "Pay to" addresses. Changes must be submitted on the CMS-855S Application Form which can be obtained by contacting a NSC representative toll-free at 866.238.9652 or downloaded from www.palmettogba.com. The form must be mailed to:

National Supplier Clearinghouse
P. O. Box 100142
Columbia, SC 29202-3142

Reminder

Previously, the DMERC used "return service requested" envelopes only when mailing checks to suppliers allowing the U.S. Postal Service to return undeliverable Medicare checks. Because some suppliers get paid through electronic funds transfer (EFT), there may be cases where a supplier does not have a correct address on file, but continues to receive payments through EFT. Effective October 1, 2002, the DMERC uses "return service requested" envelopes for all hardcopy Medicare Remittance Notices (MRNs) in addition to using them for hardcopy checks.

When the post office returns an MRN, the DMERC follows the same procedure as with returned checks. The DMERC notifies the NSC and cease generating any more payments to the supplier until the supplier furnishes a new address and that address is verified by the NSC. The NSC maintains/updates the supplier's records and provides the information to the DMERC.

Revised Proof Of Delivery Requirements

In the Spring 2004 *DMERC Dialogue* we published an article entitled "Clarification of Proof of Delivery Requirements." That article was based on instructions provided in the CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual (PIM)*, Chapter 5, Section 2.1.1. Since that publication, CMS has issued a revision of the Proof of Delivery and Delivery Methods instructions. The revisions are as follows:

• CMS Manual System, Pub. 100-8, PIM, Chapter 5, Section 2.1.1, Supplier Proof of Delivery Documentation Requirements was moved to Chapter 4, Section 4.26.
• Revised requirement: "If a supplier utilizes a delivery/shipping service or mail order that is able to provide the actual date of receipt by the beneficiary or designee, such date shall be considered the date of service on the claim." Refer to "General Requirements," number 5, below for the revised requirement.
• Removed requirement: "Claims for refills shall be the start date of the new usage period and not overlap the previous usage date." Refer to "Dispensing Refills," number 3, below for the revised requirement.
• Added requirement for items delivered to the beneficiary's home prior to a hospital or nursing facility discharge. Refer to "Delivery to Nursing Facilities or Hospitals," number 2, below for the requirement.
• Regarding delivery of items to a patient in a hospital or nursing home, the following verbiage in the PIM was revised: "The supplier should bill the date of service on the claim as the date of discharge and should use the Place of Service (POS) as 12 (Patient's Home)." The word should was revised to shall to indicate the supplier must bill the date of service as the date of discharge and must use POS 12.

We have provided a summary of the Proof of Delivery requirements for you. Please refer to the PIM for the requirements in their entirety.

General Requirements:

1. Suppliers are required to maintain proof of delivery documentation in their files for 7 years.

2. Proof of delivery documentation must be made available to the DMERC upon request.

3. Suppliers, their employees, or anyone else having a financial interest in the delivery of an item are prohibited from signing and accepting an item on behalf of a beneficiary.

4. Suppliers may deliver directly to the beneficiary or the designee (person authorized to sign and accept delivery of DME on behalf of the beneficiary). An example of proof of delivery to a beneficiary is having a signed delivery slip, and it is recommended that the delivery slip include: 1) the patient's name; 2) the quantity delivered; 3) a detailed description of the item being delivered; 4) the brand name; and 5) the serial number. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply (which is date of signature on the delivery slip) shall be the date of service on the claim.

5. If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the service's tracking slip, and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's package identification number for that package sent to the beneficiary. If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

6. Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The descriptive information concerning the DMEPOS item (i.e., the patient's name, the quantity, detailed description, brand name, and serial number) as well as the required signatures from either the beneficiary or the beneficiary's designee should be included on this invoice as well.

Dispensing Refills:

1. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill.

2. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date.

3. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product. This is regardless of which delivery

method is utilized. DMERCs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

Delivery to Nursing Facilities or Hospitals:

1. For those patients that are residents of a nursing facility, upon request from the DMERC, suppliers should obtain copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the beneficiary (e.g., nurse's notes).

2. Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility.

- A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to 2 days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and shall use the Place of Service (POS) as 12 (Patient's Home). The item must be for subsequent use in the patient's home.
- A supplier may deliver a DMEPOS item to a patient's home in anticipation of a discharge from a hospital or nursing facility. The supplier may arrange for actual delivery of the item approximately 2 days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and should use the Place of Service (POS) as 12 (Patient's Home).

3. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

4. A supplier may not bill for drugs or other DMEPOS items used by the patient prior to the patient's discharge from the hospital or a Medicare Part A nursing facility stay. Billing the DMERC for surgical dressings, urological supplies, or ostomy supplies that are provided in the hospital or during a Medicare Part A nursing facility stay is not allowed. These items are payable to the facility under Part A of Medicare. This prohibition applies even if the item is worn home by the patient from the hospital or nursing facility.

The DMERC Advisory Committee

The DAC (DMERC Advisory Committee) is a volunteer organization comprised of HME providers, State and National Associations, Manufacturer Supporters, and Industry Consultants. The primary function of the DAC is to serve as a communications vehicle between the home medical equipment (HME) industry and CIGNA Medicare (DMERC), along with the Centers for Medicare & Medicaid Services (CMS).

All 17 State Associations within Region D have a representative that serves as a voting member on the DAC. The DAC meets on a quarterly basis with Region D DMERC to address key issues throughout the region. Groups known as A-Teams, identify concerns among suppliers and consolidates these issues into a format that allows for a productive proactive resolution. The A-Teams are made up of volunteers (from 17 states) who practice in the specialty area and have significant knowledge of Medicare policies and billing practices. They collect data necessary to effectively present the issue(s) to our DMERC and CMS.

Current DAC A-Teams include: EDI/EMC, Education/Communication, HME, Infusion Therapy (I.V.), Medical Supplies and Wound Care, Orthotics and Prosthetics, Rehab, and Respiratory. The DAC also participates and is heavily invested in the Region D PCOM Advisory Committee, NSCAC (National Supplier Clearing House Advisory Committee).

The Executive Committee identifies the most urgent issues for inclusion on the DAC's quarterly question set to the DMERC. The DMERC then responds to the DAC's questions "in writing" prior to our meeting. Throughout the year if an urgent issue arises, the DAC contacts the DMERC liaison to address the issues within a timely manner.

The DAC meets twice yearly, face-to-face with the DMERC at the Medtrade East and West shows. The DAC also has two quarterly conference calls with the DMERC as well as frequent conference calls to review reimbursement and policy issues and their possible solutions. New this year, the DAC also provided an Equipment Fair in Nashville for the CIGNA Medicare offices. This event was received with positive feedback from both the DAC participants and the nearly 300 CIGNA Medicare staff that visited each of the 18 booths.

The DAC encourages and welcomes interested parties to become involved. Interested parties can nominate themselves for a potential A-Team position or someone else can nominate you. If you wish to learn more about the DAC please go to www.dacd.org. This is where you will find the posting of the Q&As we receive along with a search engine to focus on the specific topic you require, contact information for the A-teams, manufacturer supporters listed, submit a question and much more valuable information.

Besides the Web site listed above, please contact the appropriate state association below to see how you can become involved with not only the DAC, but support and gain knowledge from you state association.

The Region D DAC Executive Committee

STATE ASSOCIATIONS

AZMESA - Arizona Medical Equipment Suppliers Association (Phone (651) 439-2944, ww.azmesa.org)

CAMPS - California Assn. of Medical Product Suppliers (Phone (916) 443-115, www.campsone.org)

HCAH - Health Care Association of Hawaii (Phone (808) 521-8961)

MAMES - Midwest Assn. of Medical Equip. Suppliers *Iowa / Kansas / Missouri / Nebraska / North Dakota / South Dakota (*Phone (651) 351-5395, www.mames.com)

BIG SKY - *Idaho / Montana (*Phone (208) 433-3050, www.bigskyames.com)

NAMPS - Nevada Assn. of Medical Product Suppliers (Phone (702) 294-6680, www.namps.org)

PAMES - Pacific Association for Medical Equipment Services - *Oregon / Washington* (Phone (503) 253-9385, www.pames.org)

The Provider Communications Advisory Group (PCOM-AG)

CIGNA Medicare would like to introduce to Region D providers the PCOM Adivsory Group. This committee works to bring educational topics of interest and benefit to the provider community.

The purpose of the PCOM AG is to provide advice and recommendations for selection of provider/supplier education and training topics, as well as dissemination avenues and types and/or locations for educational forums. The PCOM AG accomplishes these tasks by soliciting input and feedback quarterly from the PCOM AG membership that encompasses the geographical diversity within Region D. The PCOM AG meets quarterly including face-to-face meetings at MedTrade Conferences (Medical Equipment Industry Trade Shows) and participates in two conference calls. During these meetings the CIGNA Provider Education and Training Staff solicits input and feedback on training topics, provider education materials and dates/locations of provider educational forums.

This year the PCOM AG along with the Region D DAC **www.dacd.org** organized an equipment fair to give the DMERC staff the opportunity to view and receive instruction on the use of products for which CIGNA Medicare processes claims.

If you are interested in serving on the PCOM AG please go to: **http://www.cignamedicare.com/wrkshp/dm/pcomm/membership.html** Information on membership requirements and a listing of specialties from which the PCOM AG needs representation are available on the Web site.

Below we have some questions and answers which may help you better understand the PCOM AG and its purpose.

Will the PCOM AG be a forum to discuss policy related issues? No, the members of the PCOM AG will provide input and feedback for selection of provider/supplier education and training topics, as well as dissemination avenues and types and/or locations for educational forums.

Is there a fee to become a member of the PCOM AG? No, fees will not be charged to participants.

As a member, will I physically have to attend every meeting? No, the PCOM AG will meet on a quarterly basis. Two meetings will be held on-site (with teleconferencing abilities) in conjunction with the MedTrade spring and fall national meetings. In addition, two other teleconferences will be held twice a year.

Can several of my co-workers join the PCOM AG with me? The PCOM AG will have a core membership of 20 to 25 members. Our goal is to have a diversity of membership, both professionally and geographically.

How do I become a member of the PCOM AG? Please review the **membership guidelines** that are posted on the Provider Communication (PCOM) Advisory Group web page on CIGNA Medicare's Web site. Then email your name, company/organization name, specialty, and contact information to the Region D Provider Communication (PCOM) contact available on the Web site.

What type of specialties will make up the PCOM AG membership? The PCOM AG will draw its members from state medical societies, provider/supplier organizations or associations, billing services, or other applicable provider/supplier organizations.

Update To The American National Standard Institute (ANSI) Codes

New Remittance Advice Remark Codes

N212 Changes processed under a Point of Service benefit.
N213 Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214 Missing/incomplete/invalid history of history of the related initial surgical procedure(s).
N215 A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.
N216 Patient is not enrolled in this portion of our benefit package.

Revised Remittance Advice Remark Codes

M39 The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
M51 Missing/incomplete/invalid procedure code(s) and/or dates.
M68 Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
M69 Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
M80 Not covered when performed during the same session/date as a previously processed service for the patient.
M81 You are required to code to the highest level of specificity.
M84 Medical code sets used must be the codes in effect at the time of service.
M116 Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.
M119 Missing/incomplete/invalid/deactivated/withdrawn National Drug Code.
MA53 Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA76 Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA92 Missing/incomplete/invalid plan information for other insurance.
MA121 Missing/incomplete/invalid date the x-ray was performed.
N40 Missing/incomplete/invalid x-ray.
N115 This decision is based on a Local Medical Review Policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.
N157 Transportation to/from this destination is not covered.
N160 The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.

Retired Remittance Advice Remark Codes

M33 Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
M34 Claim lacks the CLIA certification number.
M88 We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M92 Services subjected to review under the Home Health Medical Review Initiative.
MA06 Missing/incomplete/invalid beginning and/or ending date(s).
MA49 Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
MA85 Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
MA86 Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
MA87 Missing/incomplete/invalid insured's name for the primary payer.
MA102 Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.

N17 Per admission deductible.

New Health Care Claim Adjustment Reason Codes

156 Flexible spending account payments.
157 Payment denied/reduced because service/procedure was provided as a result of an act of war.
158 Payment denied/reduced because service/procedure was provided outside of the United States.
159 Payment denied/reduced because service/procedure was provided as a result of terrorism.
160 Payment denied/reduced because injury/ illness was the result of an activity that is a benefit exclusion.

Retired Health Care Claim Adjustment Reason Codes

113 Payment denied/reduced because service/procedure was provided outside the United States or as a result of war.
A2 Contractual Adjustment

Modified Health Care Claim Adjustment Reason Codes

161 Provider performance bonus.
162 State –mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation.

Remittance Advice Remark Code And Claim Adjustment Reason Code Update

Medlearn Matters Article Number: MM3227

Provider Types Affected - All Providers

Provider Action Needed

Be aware of the current remittance advice remark and reason codes to understand actions taken on your claims.

Background

The Centers for Medicare & Medicaid Services (CMS) maintains the remittance advice remark code list, one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG).

The complete list of these codes may be found at: **http://www.wpc-edi.com/codes/Codes.asp**

The list is updated three times per year. By July 6, 2004 all Medicare carriers and fiscal intermediaries (FIs), including the durable medical equipment carriers (DMERCs) and the Regional Home Health Intermediaries (RHHIs), will have incorporated all current remark code changes in their Medicare systems.

Remark Codes Changes

The following table summarizes remark code changes made from November 1, 2003 to February 29, 2004.

New Codes

N213 Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214 Missing/incomplete/invalid history or history of the related initial surgical procedure(s).
N215 A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own determination.

N216 Patient is not enrolled in this portion of our benefit package.

Modified Remark Codes (Effective 4/1/04)

M119 Missing/incomplete/invalid/deactivated/with drawn National Drug Code.
N115 This decision is based on a Local Medical Review Policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms. hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.

Modified Remark Codes (Effective 2/1/04

M51 Missing/incomplete/invalid procedure code(s) and/or dates.
M69 Paid at the regular rate because you did not submit documentation to justify the modified procedure code.
MA53 Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA92 Missing/incomplete/invalid plan information for other insurance.

Deactivated Remark Codes

None

Claim Adjustment Reason Code Changes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes.

The committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about changes, additions, modifications, and retirement of reason codes.

The updated list is posted three times per year, after each meeting, and the list may be found at: http://www.wpc-edi.com/codes/Codes.asp

The committee approved the following reason codes as new codes as of February 2004:

Code Current Narrative

161 Provider performance bonus
162 State-mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation.

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Frequently Asked Questions

1. In September 1999 the DMERC published an article, *Timeliness of CMN's*, which described the requirement that:

   "... if greater than 3 months passes from the time a CMN is completed and signed by the physician and the item being ordered is delivered, a new CMN will have to be completed and signed for submission of a claim...".

   The instructions for Advance Determination of Medicare Coverage (ADMC), published in June 2001, state:

   "An affirmative ADMC is only valid for items delivered within 6 months following the date of the determination. If the wheelchair is not delivered within that time, the supplier has the option of either submitting a new ADMC request (prior to providing the item) or filing a claim (after providing the item)."

   These two requirements appear to contradict one another by allowing different intervals for the validity of a CMN. Can you resolve this apparent contradiction?

   ANSWER: The September 1999 article describes the general requirements applicable to all items requiring a CMN, most of which do not make use of the ADMC process. The ADMC process allows for a longer interval and supercedes the timeframe set in the 1999 article only for those items for which a valid ADMC determination has been made.

   Thus, if an affirmative ADMC was received for the item, and the item was delivered to the patient after 90 days, a new initial CMN is not needed because the ADMC allows for delivery within 6 months. If the item did not go through the ADMC process and was delivered after 90 days, a new initial CMN is required to establish that the item is medically necessary.

   (*DMERC Region D Supplier Manual*, Chapter 4, "CMNs as Orders and Claim Submission" and Chapter 9, "Advance Determination of Medicare Coverage for Wheelchairs")

2. How does the supplier verify beneficiary equipment on file?

   ANSWER: Prior to claims submission and after the supplier has obtained as much information from the beneficiary as possible to determine whether same or similar equipment has previously been provided, the supplier may conduct a 3-way conference call with a customer service representative (CSR) and the beneficiary. Once the beneficiary answers some specific questions from the CSR, the supplier will be allowed to verify relevant equipment CIGNA Medicare has on file for that beneficiary.

3. Who and what date of service is this offset for?

   ANSWER: When the supplier receives a request to refund an overpayment, in the right hand corner of the letter there will be a Financial Control Number (FCN). If the overpayment is later offset, the FCN of the original overpayment will be located in the FCN field of the Medicare Remittance Notice (MRN) that the offset is applied. The supplier should match the FCN from the overpayment letter to the FCN on the MRN to identify the beneficiary and the date of service of the original overpayment. The supplier Interactive Voice Response (IVR) system has also been enhanced to provide the following offset information: beneficiary HICN, overpayment amount, date of service and/or the overpayment letter date and current offset balance. Claim detail information is available for FCNs that contain 34 claims or less. If the FCN contains more than 34 claims or no claim detail information is available for the FCN entered, a copy of the original overpayment letter may be obtained by faxing a request to 615.782.4623.

   (*DMERC Region D Supplier Manual*, Chapter 12, "Overpayments")

Frequently Asked Questions (cont'd)

4. What is the status of my claim?

   ANSWER: The status of your claims can be found by accessing the Interactive Voice Response (IVR) System (1.877.320.0390). The IVR will let the supplier know if the claim is still processing, paid or denied. Also, Claim Status Inquiry (CSI) allows suppliers to check the status of paper and electronic claims after they have passed the front-end edits and received a claim control number (CCN). CSI indicates whether the claim has been paid, denied, or is still pending. Additional information regarding electronic billing and CSI is available at http://www.cignamedicare.com/edi/dmerc/manuals.html.

5. My claim has been denied for same or similar equipment. Can you tell me the name and phone number of the other supplier?

   ANSWER: Once a claim has been denied for same or similar equipment, the supplier may call Customer Service (1.866.243.7272) and obtain information on the similar piece of equipment.

6. Does this patient have Medicare?

   ANSWER: Information on the eligibility of a beneficiary can be accessed through the Interactive Voice Response (IVR) system. It is a good idea during the Intake Process that the supplier obtain and make a copy of the beneficiary's Medicare card. The card will indicate the dates of their Medicare Part A and Part B entitlement. Also, the Direct Data Entry (DDE) of the 270/271 Version ANSI 4010A1 transaction set allows the supplier to check the beneficiary eligibility. Additional information regarding DDE is available at http://www.cignamedicare.com/edi/dmerc/manuals.html. Refer to the article entitled "Beneficiary Eligibility Options" in this issue.

7. My claim was denied with ANSI reason code B17, "Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current", why do I receive this type of denial?

   ANSWER: ANSI reason code B17 may be applied to paper or electronic claims for the following situations:

   - No recertification Certificate of Medical Necessity (CMN) on file
   - No CMN on file
   - No new, revised, or recert CMN on file

   Suppliers should review the claim prior to submission to determine:

   - Is the correct type of CMN being sent: initial, revision, or recertification
   - Are all sections of the CMN completed
   - Is the CMN being sent with the first claim that will be affected
   - Does the date overlap that of a CMN already on file

   CMNs should only be submitted when needed and not with every claim. CMN rejections occur when another CMN is on file in our system for the same procedure code and beneficiary. If another supplier has provided same or similar equipment previously, a current CMN may already be on file in our system.

   ANSI reason code B17 may also be applied to a claim when the supplier did not obtain a written order prior to delivery when applicable.

   A list of CMN reject error codes for electronically submitted claims is provided in the article entitled "Fixing Errors on Your CMN Reject Listing" published in the Summer 2003 *DMERC Dialogue*.

Frequently Asked Questions (cont'd)

8. I have been receiving denials for invalid ICD-9 diagnosis codes, what should I do?

   ANSWER: Obtain the correct diagnosis code(s) and resubmit the claim. ICD-9-CM is composed with three, four, or five digits. Some three-digit codes stand alone. Other three-digit codes are further subdivided by the addition of fourth or fifth digits, which provide greater specificity. Therefore, code as follows:

   - Use three-digit codes only if there are no four or five-digit codes within that code category.
   - Use four-digit codes only if there are no five-digit codes for that category.
   - Use five-digit codes when they exist in a code category.
   - Sometimes fourth and fifth digits are not available. In these cases, do not add fourth and fifth digits to valid three-digit codes (i.e., do not add zeros to valid three-digit codes).

   It is important for suppliers to use the most recent version of the ICD-9 coding book and that they code to the highest level of specificity.

   The most recent version may be obtained through the following sources:

   - Ingenix - 800.999.4600
   - CMS's Web site - www.cms.hhs.gov/medlearn/icd9code.asp
   - American Medical Association (AMA) - 800.621.8335 or www.ama-assn.org
   - National Center for Health Statistics (NCHS) - www.cdc.gov/nchs/icd9.htm

   (*DMERC Dialogue*, Spring 2004, "Frequently Asked Questions")

9. What should I do to avoid receiving a duplicate claim denial?

   ANSWER: Duplicate claims occur when a claim is submitted, then another claim is received for the same beneficiary, same item and same date of service or the claim has already been processed. Often times claims are refiled for the same services without allowing sufficient time for the original claim to process. Generally, suppliers who file paper claims are not paid before the 27th day after the date of receipt of their claims and electronic billers are not paid before the 14th day after receipt.

   Suppliers are encouraged to check the status of their claim prior to resubmitting (see question and answer number 4 above). Refer to the article entitled "Reminder to Stop Duplicate Billings" in this newsletter for more information about duplicate claims.

10. How do I find out if Medicare is the primary or secondary payer?

    ANSWER: During the Intake Process the supplier should ascertain if the beneficiary has another insurance primary to Medicare. Information regarding whether or not a Medicare Secondary Payer (MSP) record is on file for a beneficiary can be obtained from the MSP portion of the eligibility option of the supplier Interactive Voice Response (IVR) system.

    If the supplier has specific MSP questions, they can contact the Coordination of Benefits (COB) contractor at 1.800.999.1118. Additional information regarding MSP is available in the *DMERC Region D Supplier Manual*, Chapter 11.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0270

Financial Statement of Debtor

(Submitted for Government Action on Claims Due the United States)

(NOTE: Use additional sheets where space on this form is insufficient or continue on reverse side of pages.)

Authority for the solicitation of the requested information is one or more of the following: 42 CFR 405.376; 4 CFR 101, et.seq.; 31 U.S.C. 951, et seq.

The principal purpose for gathering this information is to evaluate your capacity to pay the Government's claim against you. Disclosure of the information is voluntary. If the requested information is not furnished, the Government will pursue immediate and full payment of its claim against you.

Your Social Security account number is helpful for identification, but you are not required to indicate it if you do not desire to do so.

1. Name (*debtor*)	2. Birth Date (*mo., day, yr.*)	3. Social Security No.

4. Home Address	5. Phone No.

6. Name of Spouse (*give address if different from yours*)	7. Date of Birth (*mo., day, yr.*)

Debtor Employment Data

8. Occupation	9. How Long in Present Employment?

10. Present Employer's Name	Address	Phone No.

11. Other Employment—Within Last 3 Years

Employer's Name	Address	Phone No.	Employment Dates

12. Present Monthly Income

Salary or Wages $ _____ Commissions $ _____ Other (*state source*) $ _____ Total $ _____

Spouse's Employment Data

13. Occupation	14. How Long in Present Employment?

15. Spouse's Present Employer's Name	Address	Phone No.

16. Other Employment—Within Last 3 Years

Employer's Name	Address	Phone No.	Employment Dates

17. Present Monthly Income

Salary or Wages $ _____ Commissions $ _____ Other (*state source*) $ _____ Total $ _____

Dependents

18. Total Number	Relationship	Age	Relationship	Age	Relationship	Age	19. Total Monthly Income of Dependents (*except spouse*)
							$ _____

Financial Data

20. For What Period Did You Last File a Federal Income Tax Return	21. Where Filed	22. Amount of Gross Income Reported

23. Fixed Monthly Expenses

Rent	Food	Utilities	Interest

Debt Repayments (*Including installments*)	Other (*specify*)
Total Fixed Monthly Charges	

24. Loans Payable

Owed To	Purpose & Date of Loan	Original Amount	Present Balance

25. Assets and Liabilities

Assets	(*Fair market value*)	Liabilities	
Cash	$	Bills Owed (*grocery, doctor, lawyer, etc.*)	$
Checking Accounts (*show location*)		Installment Debt (*car, furniture, clothing, etc.*)	
		Taxes Owed	
Savings Accounts (*show location*)		Income Other (*itemize)*	
Motor Vehicles Year / Make/License No.		Loans Payable (*to banks, finance company, etc.*)	
		Judgments You Owe	
Debts Owed to You (*give name of debtor*)		Real Estate Mortgages	
		Other Debts (*itemize*)	
Judgments Owed to You			
Stocks, Bonds and Other Securities (*itemize*)			
Household Furniture and Goods			
Items Used In Trade or Business			
Other Personal Property (*itemize*)			
Real Estate			
Total Assets	$	Total Liabilities	$

26. Real Estate Owned

Address	How Owned (*jointly, individually, etc.*)	Date Acquired	Cost	Unpaid Amount of Mortgage

27. Real Estate Being Purchased Under Contract

Address			Name of Seller
Contract Price	Principal Amount Still Owing	Next Cash Payment Due *(date)*	Amount *(of next payment due)*

28. Life Insurance Policies

Company	Face Amount	Cash Surrender Value	Outstanding Loans

29. All Real and Personal Property Owned by Spouse and Dependents Valued in Excess of $200 (*List each item separately)*

30. All Transfers of Property Including Cash (*by loan, gift, sale, etc.*) That You Have Made Within the Last 3 Years *(items of $300 or over)*

Date	Amount	Property Transferred	To Whom

31. Are you a party in any lawsuit now pending? ☐ Yes, give details below ☐ No

32. Are you a trustee, executor, or administrator? ☐ Yes, give details below ☐ No

33. Is anyone holding any moneys on your behalf? ☐ Yes, give details below ☐ No

34. Is there any likelihood you will receive an inheritance? ☐ Yes, from whom? ☐ No

35. Do you receive, or under any circumstances, expect to receive benefits, from any established trust, from a claim for compensation or damages, or from a contingent or future interest in property of any kind?

☐ Yes, explain below ☐ No

With knowledge of the penalties for false statements provided by 18 United States Code 1001 ($10,000 fine and/or 5 years imprisonment) and with knowledge that this financial statement is submitted by me to affect action by the Department of Health and Human Services, I certify that I believe the above statement is true and that it is a complete statement of all my income and assets, real and personal, whether held in my name or by any other.

Date

Signature

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0270. The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Supplier Guide to the Interactive Voice Response (IVR) System

CIGNA Medicare DMERC Region D has an Interactive Voice Response (IVR) System (formerly known as the ARU) at 877.320.0390 with multiple options to assist you. Claim status, outstanding checks, beneficiary Medicare eligibility, deductible and allowed amount inquiries must be conducted through our IVR system. Our customer service representatives are available at 866.243.7272 Monday - Friday from 8:00 AM - 6:00 PM (CST) for more complex inquiries that cannot be handled through the IVR.

Current features of the IVR:

- **Option 1 - Claim Information**
  Press 1 - Claim Status Inquiry (pending, denied, paid and/or applied to deductible)
  - Line by line explanation of the payment/denial
  - Appeal rights on denied claims
  - Multiple Medicare numbers
  - Multiple provider numbers

  Press 2 - Total number of claims in process
  - Number of claims in process
  - Total amount submitted

  Press 3 - To order a duplicate remittance notice

- **Option 2 - Beneficiary Information**
  Press 1 - Beneficiary Medicare Eligibility Information
  - Part B entitlement date
  - Medicare HMO enrollment information
  - Medicare Secondary Payer information

  Press 2 - Beneficiary Part B Deductible
  - Amount of deductible applied for the current calendar year

- **Option 3 - Payment Information**
  Press 1 - Allowable information
  Press 2 - Outstanding check information
  - Check date
  - Check amount

  Press 3 - Offset information
  - Claim details of original overpayment
  - Original overpayment letter date and current offset balance

- **Option 4 - General Information**
  Press 1 - To order a supplier manual, *DMERC Dialogue* or fee schedule
  Press 2 - New legislation, supplier issues and educational seminars
  Press 3 - Information on your appeal rights

There is no limit to the number of claims you can check in the IVR!!

Below are some quick tips on accessing information through the IVR:

To enter a supplier number:
- If the supplier number contains a letter, press 1. Enter the supplier number excluding the C followed by the "#" key.
- If the supplier number does not contain a letter, press 2. Enter the 10-digit number followed by the "#" key.
- The IVR will repeat the number entered. Press 1 if the number entered is correct. If you would like to reenter the number, press 2.

To enter a beneficiary's Medicare number:
If the Medicare number begins with a letter, press 1. Then,

- If the prefix letter is A, press 1
- If the prefix letters are CA, press 2
- If the prefix letters are MA, press 3
- If the prefix letters are PA, press 4
- If the prefix letters are WA, press 5
- If the prefix letters are WD, press 6
- If the prefix letters are WCA, press 7
- If the prefix letters are WCD, press 8

If it is any other letter(s) press 9

- If the prefix letter is H, press 1
- If the prefix letters are JA, press 2
- If the prefix letters are MH, press 3
- If the prefix letters are PD, press 4
- If the prefix letters are PH, press 5
- If the prefix letters are WH, press 6
- If the prefix letters are WCH, press 7

Enter the 6 or 9 numbers following the prefix followed by the # key.

If the Medicare number begins with a number, press 2. Then enter the nine-digit Medicare number. The system will then prompt you to enter the alpha character at the end of the Medicare number.

- If the letter is A, press 1
- If the letter is B, press 2
- If the letter is C, press 3
- If the letter is D, press 4
- If the letter is M, press 5
- If the letter is T, press 6
- If the letter is W, press 7
- If it is any other letter(s) press 8

To enter a letter you will need to press 2 keys. Press the key that contains the letter on your telephone key pad. Then press 1, 2 or 3 depending on the position of the letter on the telephone key pad (i.e., to enter the letter A press 2 1). Assume letters Q and Z are located on the 1 key. The Q is in the first position and the Z is in the second position (i.e., to enter the letter Z press 1 2).

If the letter is followed by a number, press 1. If the letter is followed by another letter, press 2. If no number or letter follows the letter, press the "#" key.

The IVR will repeat the Medicare number entered and will provide the first three letters of the beneficiary's last name. If correct, press 1. If you would like to reenter the Medicare number, press 2.

To enter a date of service: Use MM/DD/YY format (e.g., 01/01/03).

To enter a FCN number: Enter the first 11 digits of the FCN number followed by the "#" key.

Claim Information (Option 1)

For claim status, press 1

To receive claim status you must enter your supplier number, the HICN of the beneficiary and the date of service. (See instructions above on entering this information.) After getting the status of a claim, you may choose from the following:

- For line by line information on the claim, press 1 (Appeal rights and denial information on non-covered claims will be given.)
- To continue, press 2
- To order a duplicate remittance notice on the claim, press 1
- To continue, press 2
- To receive claim information on another claim for the same date of service, press 1
- To receive claim information on this Medicare number for a different date of service, press 2
- To receive claim information on a different Medicare number, press 3
- To have this information repeated, press 7
- To return to the main menu, press 8
- To receive information on a different provider number, press 9

For total number of claims in process, press 2

To receive the total number of claims in process you must enter your supplier number. The IVR will provide the total number of claims in process and the total submitted amount.

For a duplicate Remittance Notice, press 3

You will need your supplier number and the payment report date. (See instructions above on entering this information.) You will receive a duplicate remittance notice in the mail.

Beneficiary Information (Option 2)

For eligibility information, press 1

To verify Medicare eligibility for a beneficiary you must provide your supplier number, the beneficiary's HICN, date of birth and gender (press 1 for M or 2 for F). This option will provide the Medicare Part B entitlement date and term date, if applicable.

An option is also provided to verify if the beneficiary is enrolled in a Medicare HMO. This option will provide the type of HMO (Risk or cost), the enrollment date and term date, if applicable. Claims for a beneficiary enrolled in a "Risk" HMO should be billed to the HMO. Claims for a beneficiary enrolled in a "cost" HMO can be billed to the DMERC.

After Medicare HMO enrollment is verified you have the option to verify if Medicare is secondary payer. If there is a Medicare secondary record on file, you are instructed to contact the beneficiary for more information.

For deductible information, press 2

You will need your supplier number and the beneficiary's Medicare number. (See instructions above on entering this information.) If you are a participating provider you will receive the current year deductible applied for the Medicare number you entered. If you are non-participating you will receive (yes or no) that the deductible has been met for the current calendar year.

Supplier Guide to the Interactive Voice Response (IVR) System

Payment Information (Option 3)

For the Medicare allowed amount on a specific procedure code, press 1

You will need to specify the state where the beneficiary resides, the HCPCS code and modifiers. The current Medicare allowed amount would be provided.

To enter letters for a state code:

1. Using the letters on your touchtone telephone, enter the first letter of the state where the beneficiary resides. For example: If the beneficiary resides in California, press the 2 key.

2. Select the state desired by entering the number provided by the IVR. For example: For Alaska, press 1; for American Samoa, press 2; for Arizona, press 3; for California, press 4. (only the states serviced by Region D will be available)

To enter the HCPCS code you're looking for.

If the procedure code begins with an A, press 1
If the procedure code begins with a B, press 2
If the procedure code begins with an E, press 3
If the procedure code begins with a K, press 4
If the procedure code begins with a L, press 5
If the procedure code begins with a J, press 6
If the procedure code begins with a Q, press 7
If the procedure code begins with a V, press 8

Enter the next 4 digits of the procedure code.

If there is a modifier at the end of the procedure code, press 1, otherwise press 2.

If the procedure code is followed by a modifier:

If the modifier is NU, press 1
If the modifier is RR, press 2
If the modifier is UE, press 3
If the modifier is RRKH or RRKI, press 4
If the modifier is RRKJ, press 5

For outstanding checks issued to your supplier number, press 2

You will need to enter your supplier number. (See instructions above on entering this information.) Outstanding checks on file for the last month will be provided.

For offset information, press 3

You will need to enter your supplier number and the FCN number located on your Medicare remittance notice. You will have the option to receive claim detail information on the original overpayment and/or the original overpayment letter date and current offset balance amount. The claim detail information includes the HICN, overpayment amount and dates of service for each claim involved in the original overpayment. Claim detail information is available for FCNs that contain 34 claims or less. If the FCN contains more than 34 claims, you may request a copy of the original overpayment letter by faxing your request to 615.782.4623.

General Information (Option 4)

To Order a Supplier Manual, *DMERC Dialogue*, Fee Schedule, press 1

The address is given to send written requests for the Supplier Manual, DMERC Dialogue, and Fee Schedule.

For new legislation, supplier issues, and educational seminars, press 2

For new legislation, press 1
For supplier issues, press 2
For Webinar information, press 3
For onsite seminar information, press 4
For Provider Communication Advisory Group information, press 5

For information about your appeal rights, press 3

Information about what services are eligible for a review, the elements that should be included in a review request and the proper party to a review is provided.

To repeat these choices, press 7

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DMERC Region D Publications Designation Form

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.com) and CD-ROM. The CD-ROM includes the *DMERC Dialogue*, *DMERC Region D Supplier Manual* and update and various other supplier resources. Suppliers may choose to receive a paper copy of the *DMERC Dialogue* only in lieu of a CD-ROM.

Suppliers with multiple sites and supplier numbers may choose to eliminate publication distribution to some or all of the sites by designating that one CD-ROM be mailed to the supplier's corporate address. The CD-ROM will be mailed to the designated "Mail To" address for the corporate office on the supplier's enrollment application.

Complete the applicable section(s) below to **change** the method of publications distribution preferred. You may also submit your request in writing on your company letterhead to: CIGNA Medicare, Communications Department, Two Vantage Way, Nashville, TN 37228 or by fax: 615.782.4445.

Request for Paper Copy – DMERC Dialogue (Opt-Out of CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

Reason for requesting paper version:
- ☐ No personal computer
- ☐ No CD-ROM drive
- ☐ Prefer paper copy
- ☐ Other _____

(List additional supplier numbers to be included in this request on the back of this form.)

Request for CD-ROM (Opt-In or return to CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

(List additional supplier numbers to be included in this request on the back of this form.)

Request for elimination of CD-ROM distribution to multiple sites-Corporate address designation

_____
SUPPLIER NUMBER TO REMAIN ON PUBLICATIONS MAIL LIST

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

- ☐ Eliminate CD-ROM for all supplier numbers with the same "mail to" address shown on this form. [When this option is selected all newly assigned supplier numbers will be included in this request.]
- ☐ Eliminate CD-ROM only for the supplier numbers listed on the back of this form.

(List supplier numbers to be excluded from the publications mail list on the back of this form.)

DMERC REGION D

07/01/2004

DMERC Region D Publications Designation Form (cont'd)

List additional supplier numbers to be included in the request on the front of this form.

SUPPLIER NUMBER(S):

SUPPLIER NUMBER(S):

The privacy of our customers is important to CIGNA Medicare. Personally identifying information that is collected will be used only in connection with the specified request. CIGNA Medicare will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

MEDICARE REVIEW REQUEST FORM

DATE _____

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22995
Nashville, TN 37202

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: ☐ DME ☐ Oxygen ☐ Supplies ☐ Orthotics ☐ Prosthetics ☐ ESRD ☐ PEN ☐ IV Therapy
☐ Other _____

CLAIM INFORMATION

☐ Assigned ☐ Non-Assigned

Service Date	HCPCS	Charge(s)	Internal Control Number (ICN)	Denial Reason/ ANSI Code	Date of Initial Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

Please see the Summer 2000 *DMERC Dialogue* for additional documentation requirements.

_____ CMS 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
Other_____

CONTACT INFORMATION

PROVIDER: (Contact Name and Signature)	BENEFICIARY: (Contact Name - Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

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Medicare Hearing Request Form

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22263
Nashville TN 37202

Date _____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

Type Of Hearing **____ On the Record** **_____ Telephone** **____ Inperson**

CLAIM INFORMATION **____** Assigned **____** Non-Assigned

Service Date	HCPCS	Charge(s)	Claim Control Number	Review DCN	Date of Review Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

_____ HCFA 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Review Letter
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
_____ Other _____

CONTACT INFORMATION

PROVIDER: Contact Name and Signature)	Beneficiary: (Contact Name – Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

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Medicare Administrative Law Judge Request Form

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22263
Nashville TN 37202

Date _____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

Type Of Hearing **On the Record** **Inperson**

CLAIM INFORMATION Assigned Non-Assigned

Service Date	HCPCS	Charge(s)	Claim Control Number	Hearing Case Number	Date of Hearing Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

_____ HCFA 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Review Letter
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
_____ Hearing Letter

CONTACT INFORMATION

PROVIDER: Contact Name and Signature)	Beneficiary: (Contact Name – Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

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DMERC Region D Publication Order Form

Name:

Company Name:

Address:

City:	**State:**	**Zip:**

Email:

Note: Government agencies, state associations, CMS, CIGNA employees and other insurance companies do not need to submit payment.

Subscription (4 quarterly publications) $40.00

Region D *DMERC Dialogue*_____ (quantity) ***Subtotal*** **$_____**

CD-ROM _____ (quantity) (Includes *DMERC Dialogue*, *DMERC Region D Supplier Manual* and updates and various other materials.) ***Subtotal*** **$_____**

Individual Publication Requests

Region D *DMERC Dialogue** **($10.00 each issue)** (*Previous issues may include the supplier manual update.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

CD-ROM ($10.00 each)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

DMERC Region D Supplier Manual
$40.00 per manual _____(quantity) ***Subtotal*** **$_____**

DMERC Region D Supplier Manual Update* **($10.00 each)** (*Previous updates may include the *DMERC Dialogue.)*

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

NOTE: Beginning Spring 2003, hardcopies of supplier manual updates are no longer mailed and must be downloaded from our Web site at http://www.cignamedicare.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

DMERC DMEPOS Fee Schedule* ($10.00 each) (*DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.)

Quantity_____ Year _____ ***Subtotal*** **$_____**

Total Amount Due **$_____**

Payment Information

Checks or money orders should be made payable to CIGNA HealthCare Medicare Administration. Send completed order form and payment (if applicable) to:

Connecticut General Life Insurance Company
Attn: DMERC Publication Fulfillment Center
P. O. Box 360295
Pittsburgh, PA 15251-0295

If you have not billed CIGNA Medicare within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary CD-ROM or hardcopy *DMERC Dialogue.* Region D publications are available at http://www.cignamedicare.com/dmerc/index.html.

(Rev. 10/2003)

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Suggested Intake Form

Order taken by:	Date:
Telephone:	Referral Person Calling in Order:

BENEFICIARY INFORMATION

Name:	Date of Birth:
Street Address:	Gender: ☐ Male ☐ Female
City, State, Zip:	Weight: / Height:
Telephone:	Medicare Number:

Name of Legally Responsible Representative:

Relationship to beneficiary:

Street Address:

City, State, Zip: / Telephone:

ORDERING PHYSICIAN INFORMATION

Name:	UPIN #:
Street Address:	
City, State, Zip:	Telephone:
Specialty:	

QUESTIONS FOR THE BENEFICIARY

Has the beneficiary ever received the same or similar supplies/equipment?	☐ Yes ☐ No
If yes, list equipment/supplies:	
Who was it purchased or rented from?	
Date purchased or if rented, how many months? / Date of past setup: / Date equipment was returned:	
Was item returned to original supplier?	☐ Yes ☐ No
Why was the item returned?	
Is the item being replaced?	☐ Yes ☐ No
Is there a new medical necessity?	☐ Yes ☐ No
Describe condition for previous need:	
Describe new/changed condition:	
Is the beneficiary enrolled in a Medicare HMO/managed care program ?	☐ Yes ☐ No
Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)?	☐ Yes ☐ No

QUESTIONS FOR THE SUPPLIER

If providing repairs on equipment obtain the following information for the item being repaired:

Manufacturer:	Model Name or Number:	Serial Number:	Purchase Date:

Reason or nature of repairs:	
Do you have medical necessity to file for repairs?	
Does beneficiary meet criteria for item being repaired? ☐ Yes ☐ No	Where will the item be used?
Did I photocopy the Medicare card and/or other insurance cards?	☐ Yes ☐ No
Do I have a dispensing order and/or a detailed written order?	☐ Yes ☐ No
Will I need a Certificate of Medical Necessity (CMN)?	☐ Yes ☐ No
Do I have supporting documentation on file to meet medical necessity?	☐ Yes ☐ No
Should I obtain an Advanced Beneficiary Notice (ABN)?	☐ Yes ☐ No
What is the primary diagnosis? / List any other diagnoses if applicable:	
Is Medicare the beneficiary's ☐ primary or ☐ secondary insurer?	
Is the beneficiary or beneficiary's spouse employed?	☐ Yes ☐ No
Is the current condition related to employment, auto or other accident?	☐ Yes ☐ No
Is the beneficiary nearing Medicare eligibility? ☐ Yes ☐ No If yes, give eligibility date:	
Do I need to obtain a one-time authorization form?	☐ Yes ☐ No
Did the beneficiary sign and date this intake form?	☐ Yes ☐ No
Beneficiary Signature:	Date Signed:

This is just a **suggested** intake form and suppliers can model one to fit their particular type of business. For example if you are providing oxygen there may be certain questions you need to ask regarding oxygen patients or if you are providing wheelchairs there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in anyway replace obtaining an Advanced Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the *DMERC Region D Supplier Manual*, Chapter 3, for information about same or similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.

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Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

Chain Home Office:
- ❑ Check here if EFT payment is being made to the Home Office of Chain Organization *(Attach letter Authorizing EFT payment to Chain Home Office)*

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only)* _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature_____Date_____

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

Notes

Notes

Customer Service Available

Telephone Inquiries—Customer Service Agents are available from 8:00 am to 6:00 pm CST, Monday through Friday. The Interactive Voice Response (IVR) System is available any time as long as the mainframe system is functional.

IVR System*:* 877.320.0390 ***Supplier Help Line****:* 866.243.7272 ***Beneficiary Help Line****:* 800.899.7095

Paper Claim Submission & Written Inquiries:
CIGNA Medicare
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Medicare
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Medicare
DMERC Hearings
PO Box 22263
Nashville TN 37202

Local Medical Review Policies (LMRPs), Local Coverage Determinations (LCDs), and Policy Articles

LMRPs, LCDs and Policy Articles are available to view and download on the CIGNA Medicare Web site (http://www.cignamedicare.com/dmerc/lmrp_lcd/index.html) and the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired policies. Paper copies of policies are available upon request by writing to: CIGNA Medicare, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

Requests may also be made by contacting the CIGNA Medicare Online Help Center at http://www.cignamedicare.com/dmerc/resource.html. Requests for retired policies must include the name of the policy and the date the desired policy was in effect. In addition, you must provide a contact name, phone number and an address to which the policy may be mailed. CIGNA Medicare regrets we will not be able to fax or e-mail copies of the retired policies to the requester.

Supplier Application Packages and Changes of Address—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC) at the following: National Supplier Clearinghouse, PO Box 100142, Columbia SC 29202-3142, Phone: 866.238.9652, Web site: www.palmettogba.com.

Also, remember that no checks will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 866.224.3094, or send us e-mail at www.cignamedicare.com/customer_service.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 877.735.1326.

Overpayments/Refunds—When refunding a check, make it payable to CGLIC - Medicare and send it to:

CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DMERC Dialogue *...a service of*

CIGNA Medicare
DMERC Region D
PO Box 690
Nashville TN 37202

Region D DMERC Serves. . .

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

The *DMERC Dialogue*, together with occasional special releases, serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

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